UNDERSTANDING DYNAMICS OF SEXUAL VIOLENCE:

STUDY OF CASE RECORDS

CEHAT and MCGM

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Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai

Municipal Corporation of Greater Mumbai (MCGM)

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Preface

Violence is now widely recognised as a global public health concern. Evidence shows that violence, which may take various forms such, caste/race violence, homicide, suicide, domestic violence, rape, or that inflicted in war and situations of armed conflict, is common, and causes immediate and long-term health and social consequences for survivors/victims and their communities. In the context of sexual violence, women and children have an invariable contact with the health system. They are either brought by investigative agencies for medico legal examination, or survivors reach the heath system for treatment of health conseuences arising out of rape/sexual violence. Glaring gaps in the response to sexual violence survivors were raised nationally only following the brutal sexual and physical violence of a young Delhi Professional. The public outcry and consistent momentum led to changes in the laws on sexual violence, and also in directing different systems to create mechanisms for prompt and sensitive services for rape survivors. This led to the setting up of Justice Verma Committee (JVC) to review the response of all stake holders and propose changes in the rape law as well as make recommendations to different sectors to improve their response to rape.

I am happy to state that MCGM hospitals have been the first in India to lead the moment on comprephensive health care services for sexual violence since 2008. Since 2008, three of the MCGM hospitals, KB Bhabha Hospital, Rajawadi Hospital and Cooper hospitals in collaboration with CEHAT initiated the implementation of medico legal care for survivors of sexual violence as per WHO protocols and guidelines of 2003. As a part of this collaboration Health care providers were trained to implement informed consent, seek detailed history of sexual violence, collect relevant medical evidence, provide reasoned medical opinion, comprensive documentation and psychological first aid. Such an implementation led to a volume of evidence such as forms of sexual violence, its impact on health as well as circumstances under which sexual violence occurs. This evidence was examined by JVC and the recommendations for health system and health

providers directly flow from the work of these 3 hospitals. The Ministry of Health and Family welfare (MoHFW) designed the guidelines and proforma based on the JVC recommendations. In the past 10 years the model of comprehensive health care response to sexual violence was replicated in several other MCGM hospitals. It is a proud moment for me as a director of MCGM hospitals to state that we are the first organization to implement MoHFW medico legal guidelines for sexual violence survivors issued by GoI.

This report provides important learning and insights into the interface between hospitals and survivors of sexual violence. It also presents analysis on contentious issues such as marital rape, consensual sexual relations between adolescents, and how health care providers fulfilled their ethical obligations. This will be an important learning document to all those who are keen to create a comprehensive response to sexual violence. The report also highlights that there is a need to establish long term engagement between health institutions and survivors of sexual violence. I express my best wishes to the entire team of CEHAT and collaborating institutions.

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Acknowledgements

The report "Understanding the Dynamics of Sexual Violence- Study of case records" is an outcome of an ongoing collaboration between MCGM and CEHAT towards implementing a comprehensive health care response to survivors of sexual violence. This has been a decade long ongoing collaboration (2008-2018). CEHAT-MCGM established the first hospital based crisis intervention department, Dilaasa in 2001. In 2008, MCGM pioneered the establishment of a comprehensive health care model to survivors of sexual violence. Several administrators, health care providers and community development officers of MCGM made significant contributions to the development of sensitive practices towards Violence Against Women (VAW).

We would like to begin by acknowledging Dr Seema Malik and her efforts to insitutionalise a health care response to VAW. We take this opportunity to thank Dr Roopa Prasad and Dr Udayan Palnitkar for their contribution towards development of comprehensive services. We thank medico legal records department Mr. Vikas Gharat in KB Bhaha hospital, Ms Sanchita in Rajawadi hospital and Ms Jaya Nikale in Cooper who provided medico legal records in an organised manner

We thank CEHAT's Programme Development Committee (PDC) members, Dr Padmini Swaminathan, Dr U Vindhya, Dr Vibhuti Patel, Dr Renu Khanna and Dr Padma Prakash for reviewing the report. We thank Dr Jagadeesh N Reddy and Dr Padma Bhate-Deosthali for being available to the teams to discuss challenging situations and advising on navigating different systems. We also thank Advocate Manisha Tulpule for guiding CEHAT team with legal advice and also providing legal guidance to survivors.

We take this opportunity to thank Dr Padma Bhate-Deosthali for leading the conceptualising and drafting the report along with Sangeeta Rege and Sanjida Arora.

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1. Introduction

Domestic violence and sexual violence are the most pervasive forms of gender-based violence, cutting across caste, class, race, religion and socio-economic background. World Health Organisation (WHO) estimates that one in three women across the world will experience physical and/or sexual violence by a partner and sexual violence by a non-partner. (WHO, 2013). The prevalence of non-partner sexual violence was 4.9 per cent. Sexual violence by strangers is a small percentage of all incidences of sexual violence. The National Crime Record Bureau (NCRB) recorded a total of 124,791 sexual offences against women in 2014.

The public protests following the brutal assault of a young health professional compelled the Government of India to take cognizance of sexual violence. In addition to various general issues, women's groups, health activists and institutions, including CEHAT, drew attention to the insensitive practices in the health sector. They especiallypointed to the use of unscientific and anti-women practices within forensic medicine such as the use of the two-finger test that was used wrongly to determine the status of virginity of the survivor and to assess her past sexual history. Several lawyers and activists spoke out against the insensitivity of health providers. A petition by CEHAT and Human Rights Watch (HRW) against the use of two-finger test was endorsed by several institutions, researchers, lawyers, doctors and submitted to the Prime Minister's Office (PMO). As a strategy, CEHAT focused on good practice as it had set up a model in collaboration with the MCGM that adhered to international standards. This was functional in three hospitals since 2008 and had provided comprehensive care and treatment to a large number of rape survivors. (Rege et al, 2014).

The state responded immediately by appointing a three-member committee headed by Justice Verma to examine the lacunae in criminal laws and their enforcement in cases of "sexual assault of extreme nature against women". Within a month, in January 2013, the Committee (JVC)[1] produced a comprehensive detailed analysis and recommendations. CEHAT made a written submission along with the Lawyers Collective to the JVC, an oral presentation before the members, and consistently worked with the media and others to focus on the need to upscale this model.The JVC report mapped the socio-economic, cultural, political and juridical basis for sexual violence against women. It asserted that

[1] The Committee was constituted by GOI Notification No. S0 (3003)E, dated December 23, 2012 to look into possible amendments to the Criminal Law to provide for quicker trial and enhanced punishment for criminals committing sexual assault of extreme nature against women. The J. Verma Committee received emails from a cross section of people and heard representatives of thewomen's movement.

rape was a violation of a woman's sexual autonomy and bodily integrity. The report made clear recommendations about what needed to change within various institutions so that they could respond sensitively to survivors of sexual violence and guarantee justice and care for them.

The JVC report included an entire chapter that addressed institutional bias to rape within the health system. Amongst the recommendations pertaining to the health sector, one was for developing uniform protocols and guidelines in responding to sexual violence. This included strong recommendations for the removal of insensitive and unscientific procedures that traumatize survivors. The report further recommended the setting up of services for the provision of psycho-social care and rehabilitation of survivors of sexual violence thus clearly spelling out a major responsibility for the health system in India.

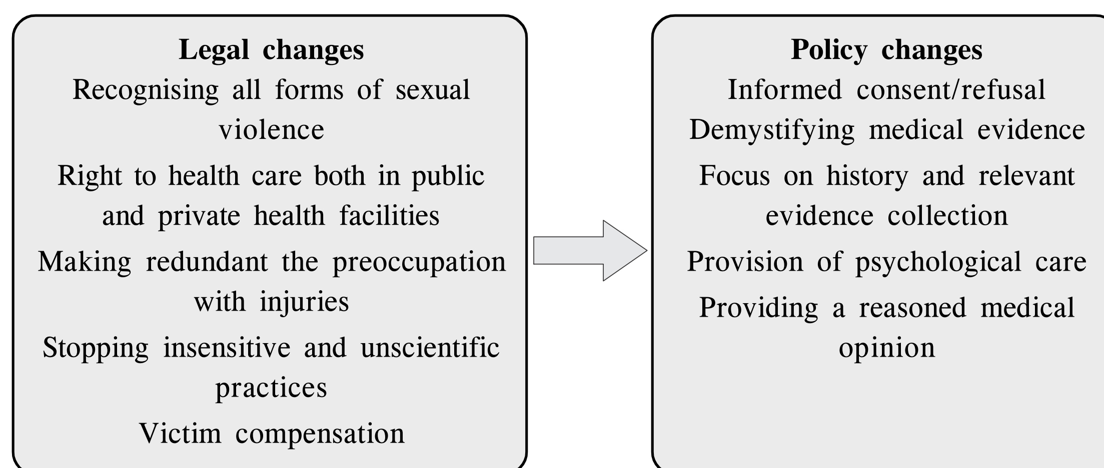
Until 2017, the Ministry of Health in India had no policy or plan for responding to VAW. In that year, the MoHFW included response to gender based violence in its policy by clearly mandating gender training of health providers, making hospitals women-friendly and providing care to survivors/victims of gender based violence. This is despite legal mandate and WHO guidelines for health systems to recognise VAW as a public health issue.

1.1 Legal and Policy Changes

The Criminal Law Amendment Act (CLA) 2013 expanded the definition of rape to include all forms of sexual violence-penetrative (oral, anal, vaginal) including by objects/weapons/ fingers and non-penetrative (touching, fondling, stalking, disrobing etc). It recognised the right to treatment for all survivors of sexual violence in all public and private health care facilities. Failure to treat is now an offence under the law. The law further disallows any reference to past sexual practices of the survivor. The Criminal Law Amendment (CLA) 2013 has made a strong case for positively transforming the response of the health sector to sexual violence.

Taking cognizance of the lack of uniform protocols and gaps in provision of medico legal care to survivors of sexual violence, the recommendations of the JVC, the CLA 2013 and Protection of Children from Sexual Offences (POCSO) 2012, the Ministry of Health and Family Welfare (MoHFW) set up a national committee comprising experts to formulate uniform protocol and guidelines for health professionals in responding to sexual violence. While doing so, the ministry took cognizance of international standards, especially the World Health Organisation (WHO) Guidelines on Medico Legal Care (2003) and Clinical

and Policy Guidelines for Responding to Intimate Partner Violence (IPV) and Sexual Assault (2013). The committee has drawn from the available evidence from health sector interventions, legal and other expert opinions and voices of survivors. This is a most significant achievement since it is the first national directive to the health sector on responding to violence.



1.2 Medico-legal guidelines for responding to sexual violence

The health ministry's guidelines were an outcome of an intensive process led by the then Health Secretary, Keshav Desiraju. Discussions were held with multiple stakeholders, viz., administrators, forensic experts, clinicians, researchers, lawyers as well as representatives of the Ministry of Women and Child Development, the Home Ministry and the Ministry of Law and Justice. The guidelines were disseminated through a national workshop held in collaboration with the WHO in March 2014 that was attended by senior health functionaries of all states and union territories. Since then, the Health Ministry has conducted five regional workshops in collaboration with the WHO for doctors from various states to train them in the skills required to operationalise the guidelines.

The Health Ministry's guidelines provide a clear directive to all health facilities to ensure that survivors of all forms of sexual violence, rape and incest - including people who face marginalisation based on disability, sexual orientation, caste, religion and class - have immediate access to healthcare services. They include immediate and follow-up treatment, post-rape care including emergency contraception, post-exposure prophylaxis for HIV prevention and access to safe abortion services, police protection, emergency shelter, documentation of cases, forensic services and referrals for legal aid and other services.

They recognise the need to create an enabling environment for survivors to speak out about abuse without fear of being blamed, where they can receive empathetic support in their quest for justice and rebuild their lives after the assault.

1.2.1 Status of the implementation of the MoHFW guidelines

It has been four years since the MoHFW issued guidelines and protocols on providing unbiased and sensitive treatment to survivors of sexual violence. These guidelines were circulated to all states in April 2014. So far, only nine states have issued government orders or circulars stating that health facilities must follow the guidelines. Other states have not even taken this small step. The Criminal Law Amendment 2013 makes it mandatory for all private hospitals to respond to survivors of rape. But while some private medical associations may have conducted training related to the POCSO Act, they have not taken any broad initiatives to adopt the health ministry guidelines on sexual violence.

While the WHO, UNFPA, MoHFW and CEHAT have conducted training programmes, only the MCGM has printed these proformas and ensured their availability in all its hospitals. Survivors of sexual violence continue to be subjected to unscientific medical practices such as irrelevant and invasive swab collections, comments on their past sexual practices and comments raising doubts about their complaints. They continue to face humiliation, delays and insensitivity from health professionals, adding to their trauma. Although the guidelines point out that survivors need to be given first-line psychological support, health providers continue to only conduct forensic examination, ignoring the therapeutic needs of survivors. This is borne out by the Human Rights Watch (HRW) Report of 2017[2] and CEHAT's ongoing work in 11 states on improving the health sector response to VAW and children.

Clearly the state health departments need to make concerted efforts to implement the health ministry's guidelines in entirety so that survivors will receive the full benefits of medico legal care which will aid their rehabilitation and improve their access to justice.

All state governments need to adopt these guidelines and make them available at all levels of the health system. Secondly, health departments need to create action plans for implementing the guidelines. State-level training plans need to be developed with facility level monitoring mechanisms to assess quality of the healthcare response to sexual violence survivors. Healthcare providers need to understand and accept that sexual violence is a

[2] "Everyone Blames Me",Barriers to Justice and Support Services for Sexual Assault Survivors in India, Human Rights Watch 2017.

critical health issue and good quality health services can help survivors in overcoming trauma and strengthening their resolve to seek justice.

The Nirbhaya centres, or the One Stop Centre (OSCs) have been another initiative of the GoI. The Ministry of Women and Child Department (MWCD) reports that 166 OSCs have been set up across the country and most of these are located within public hospitals. However, the initiative has not been invested with a public health perspective. In consequence, these are stand-alone centres, run by the MWCD, with little connection or well-defined collaboration with the rest of the hospital's systems. No effort has been made to ensure that the MoHFW guidelines on medico-legal examination of survivors of sexual violence are being followed in these OSCs. There was no systematic training of health professionals in the hospitals where the OSCs were set up, so no referrals from the hospitals were evident. This is another example of the lack of coordination between the ministries (NIPPCID Report, 2016). Given that survivors of violence suffer physical and/or psychological consequences and support from health professionals in critical points could also play an important role in documenting violence, this lack of attention to developing a comprehensive approach is disappointing.

1.2.2 Knee jerk reaction to MoHFW guidelines and the discourse on improving response of hospitals

In April 2014, with the publication and circulation of the MoHFW guidelines, the states were recommended to adopt them immediately. In India healthcare comes under the sole jurisdiction of the states and not the central government. The Centre can only recommend practices and not insist on their adoption. However, given the seriousness of the issue, the central ministry could well have declared the guidelines as mandatory, considering them under medico-legal matters that come under the joint responsibility of the state and the centre (that is, the concurrent list).

The states have responded in various ways. There have been knee jerk reactions from states such as Delhi and Kerala. In May 2014, barely a month after the issuance of the central government's guidelines, the health department of the Delhi government appointed a review committee of three doctors. The committee in its report insisted that these guidelines may not be followed without being amended to include the use of the two-finger test in some cases. However, a closer reading of the committee report shows that it has confused the per vagina examination with the two-finger test. The law and the guidelines have banned the two-finger test which is a forensic test used to determine the size of the vaginal introitus. It is now well-acknowledged that the two-finger test provides no proof

or evidence of the nature of the crime and had often led to biased conclusions of the character of the rape survivor/victim, which is why the health ministry guidelines have banned the test. On the other hand, a per vaginal exam is a clinical practice, which requires an internal vaginal examination, but is done for diagnosis of infection, injury and/or presence of a foreign body.

The guidelines require doctors to clearly state why a PV (per vaginum) or PS (per speculum) examination needs to be performed. This was in order to bring some clarity on the routine performance of PV for all rape survivors, regardless of whether it was medically inidicated.

The committee report prompted the voicing of several similar opinions across medical and civil society and there was much confusion over the PV and two-finger test! While the Delhi government was severely critical of the committee's recommendations on this county to begin with, it subsequently withdrew its comments almost immediately after severe criticism. The state finally adopted the MoHFW guidelines in 2017 only after the Delhi High Court intervened through a pioneering project that trained more than 150 health professionals from Delhi Hospitals on medico-legal procedures for responding to sexual violence.

The health department of Kerala produced its own manual and protocol and claimed to have adopted the Central Health Ministry guidelines with modifications in 2016. The modifications reinsert unscientific and gender insensitive practices of the past. The protocol continues to ask doctors to document status of the hymen, status of pubic hair, the person's height and weight and other characteristics that do not verify or negate the nature of the crime. The department's manual does not provide guidance on history seeking procedures nor on the documentation of activities that lead to the loss of medical evidence. The manual makes no mention of the need to obtain informed consent from the survivors or of providing psychological first aid. CEHAT has raised serious issues with the Kerala protocol in December 2017 and a joint letter signed by several groups and individuals was submitted to the MoHFW, Dept of Health Kerala and the National Health Systems Resource Centre (NHSRC) in December 2017 (IJME, 2017)

Another initiative in dealing with rape survivors in the health system was the setting up of rape crisis centres in some hospitals in Delhi. That this has not got off the ground is evident from inquires and visits from visits by civil society organisations. Most hospitals had merely marked out and designated a separate room for examination and collection of medical evidence in instances of sexual assault survivors (CBGA, 2016). No effort has

been made to provide comprehensive services such as counselling support, shelter services, and referrals to legal aid. Rape survivors are merely referred to the Delhi Commission for women for counseling and other care. The existing hospital team of counsellors and psychologists has not been assigned any role, with the psychological care outsourced. The focus is on use of safe kits for evidence collection in a mechanical manner.

The All India Institute of Medical Sciences (AIIMS) in New Delhi is using its own protocol developed in 2014. The hospital guidelines do not require doctors to record their medical opinion after examining the survivor. Contrarily, the Criminal Procedure Code and the Health Ministry guidelines, mandate that the doctor's interpretation of the findings have to be made available, because this can assist a court in determining the occurrence of sexual assault or rape. Without this requirement in the AIIMS guidelines, doctors may escape responsibility of offering their medical opinion on the findings. The presence or absence of medical evidence can be explained only by the doctor based on history and clinical examination.

In Maharashtra, Orissa and Madhya Pradesh, while the guidelines have been adopted, they have not been circulated to health facilities, and the doctors continue to use old gender insensitive practices.

1.3 Role of health systems

The WHO Clinical Guidelines of 2013 were developed focusing on low and middle income countries and the specific recommendations made therein need to be translated into a clear policy document of a health systems response to VAW by the MoHFW. In the absence of a clear policy the response will remain chequered and not systematic. Despite legislations on responding to violence against women and explicit role of the health sector mentioned therein, there are several challenges in implementing these roles on the ground. One of the main reasons is the lack of technical and financial resources for implementation of the expected roles and responsibilities of the health sector vis-a-vis survivors of violence.

In May 2013, the World Health Assembly in response to a demand from India and five other countries passed a global action plan for responding to VAW. After a long consultative process the plan was adapted by several countries at the 69th World Health Assembly in May 2016. India is committed to the Global plan of action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls and against children. The global plan of action will contribute towards the achievement of the Sustainable Development Goals

including Goal 5 (Achieve Gender Equality and Empower All Women and Girls) and Goal 16 (Promote Peace, Justice and Inclusive Societies), as well as Goal 3 (Ensure Healthy Lives and Promote Well-being for all at all Ages).

The global plan recommends actions under four strategic directions:

1. Strengthening health system leadership and governance.
2. Strengthening health service delivery and health workers'/providers' capacity to respond to violence, in particular against women and against children.
3. Strengthen programming to prevent interpersonal violence, in particular against women and girls, and against children.
4. Improve information and evidence.

The WHO has also laid down clear indicators for monitoring progress made by countries under the GPA:

1. Include health care services to address intimate partner violence and comprehensive post-rape care in line, with WHO guidelines, in national health or sexual and reproductive health plans or policies.
2. Develop or update their national guidelines or protocols for the health system response to women experiencing violence, consistent with international human rights standards and WHO guidelines.
3. Provide comprehensive post-rape care in a medical facility in every territorial and/or administrative unit, consistent with WHO guidelines.
4. Have a national multisectoral plan which includes the health system and which proposes at least one strategy to prevent violence against women and girls.
5. Have carried out a population-based, nationally representative study/ survey on VAW or that have included a module on violence against women in other population-based demographic or health surveys within the past five years, disaggregated by age, ethnicity, socioeconomic status, other.

1.4 Emerging evidence from the comprehensive gender sensitive model functioning in Mumbai hospitals

The work being carried out by CEHAT and the MCGM to provide comprehensive care to all survivors of sexual violence provides a model that the Ministry of Health (MoH) may use as a guide in setting up and monitoring services. This CEHAT-MCGM initiative was built on the experience of running two crisis centres for survivors of domestic violence for more than a decade. The most critical element of the model was formulating gender-sensitive and uniform proformas, guidelines that provided step-by-step instructions on how to conduct an examination and established standard operating procedures for comprehensive care. Senior officials of the Forensic Science Laboratory reviewed the protocol and offered their suggestions.

The core components of this model, that has been functioning in three municipal hospitals since 2008 are as follows:

- Seeking informed consent for all aspects of the medico-legal examination;
- eliciting history of sexual violence and documenting it;
- examination and relevant evidence collection;
- formulating a medical opinion based on history, clinical findings and forensic evidence;
- providing treatment and psychosocial support, and
- maintaining a chain of custody.

The focus has been on informed consent, detailed documentation of the assault, formulation of medical opinion based on clinical findings, factors leading to the possible loss of evidence - such as delay in reporting, bathing/douching/menstruating/urinating - circumstances of abuse such as verbal threats, numbing due to fear, and so on.

1.4.1 Understanding the numbers

The rising numbers of rape / Sexual Violence (SV) cases coming to hospitals needs to be understood in context. The three hospitals had received 100 cases between April 2008 and March 2012 and 628 cases between April 2012 and March 2015. In other words, from a mere 25 cases per year the referrals have gone up to 209 per year. The rise in the numbers is not a surprise as there has been an overall increase in reporting of cases of sexual violence.

The incident of rape and murder of young professional that is widely known as the Nirbhaya incident triggered a massive campaign against sexual violence. The incident shook the county and the media reported extensively on the case and the poor response of institutions such as police, health institutions and courts. The campaign following the Nirbhaya incident created a lot of awareness about rape as evidenced in a rise in reporting of all cases of sexual violence but more amongst adolescent and adult women. There was a 35.2 per cent increase in the number of rapes reported in the country - from 24,923 in 2012 to 33,707 in 2013 and the trend continued with 36,735 in 2014 and 34,651 in 2015 (as per data from the NCRB). Other forms of sexual offences too have increased from 54,524 in 2012 to 83,328 in 2013, and the rising trend continues.

Table 1.1 Reported cases of SV

	2012	**2013**	**2014**	**2015**
Rape	24923	33707	36735	34651
Other forms of SV	54524	83328	96202	95541

Source: NCRB

The sustained campaign and the changes in law have had an impact on society in general and on the reporting of sexual violence. It was also seen in the number of survivors reaching the three hospitals too. In the 2013, there were 100 cases registered in one year, increasing to 358 cases of SV in 2014. The fact that these three hospitals of the MCGM were constantly in the media for providing good quality services to sexual violence also may have led to more survivors coming or being brought by the police.

The other factor affecting the increase in numbers of cases, are some of the specific changes in the rape law as per the CLA 2013. One of these is that the definition of rape was expanded from peno-vaginal penetration to include all orifices (anus, mouth and vagina) and penetration by penis, finger or object. This meant that survivors now came forward and report other forms of sexual violence which were hitherto not considered as rape. The second significant amendment was that under Section 166 A the police could be punished for not registering a First Information Report (FIR). This probably was the reason for the large number of survivors brought to hospitals by the police. The third likely contributory factor was the change in age of consent for sexual activity to 18 years. So all cases of consensual sex, as seen in elopement or runaway couples, also began to be registered as rape and brought to hospital for medico-legal examination.

An important component of the CEHAT-MCGM model was building the capacity of healthcare providers to carry out medico-legal examinations, understand the impact and health consequences of assault, and the provision of care. The training also included a perspective on the dynamics of sexual violence, and the myths related to it to enable them to overcome biases. A crisis interventionist was available at all times, responding to any query of the examining physicians, dealing with the police and the CWC, and providing crisis intervention services to the survivor and her family.

This report presents the profile of survivors reporting to these hospitals, the nature of sexual violence experienced by them, the circumstances surrounding the incident and health consequences.

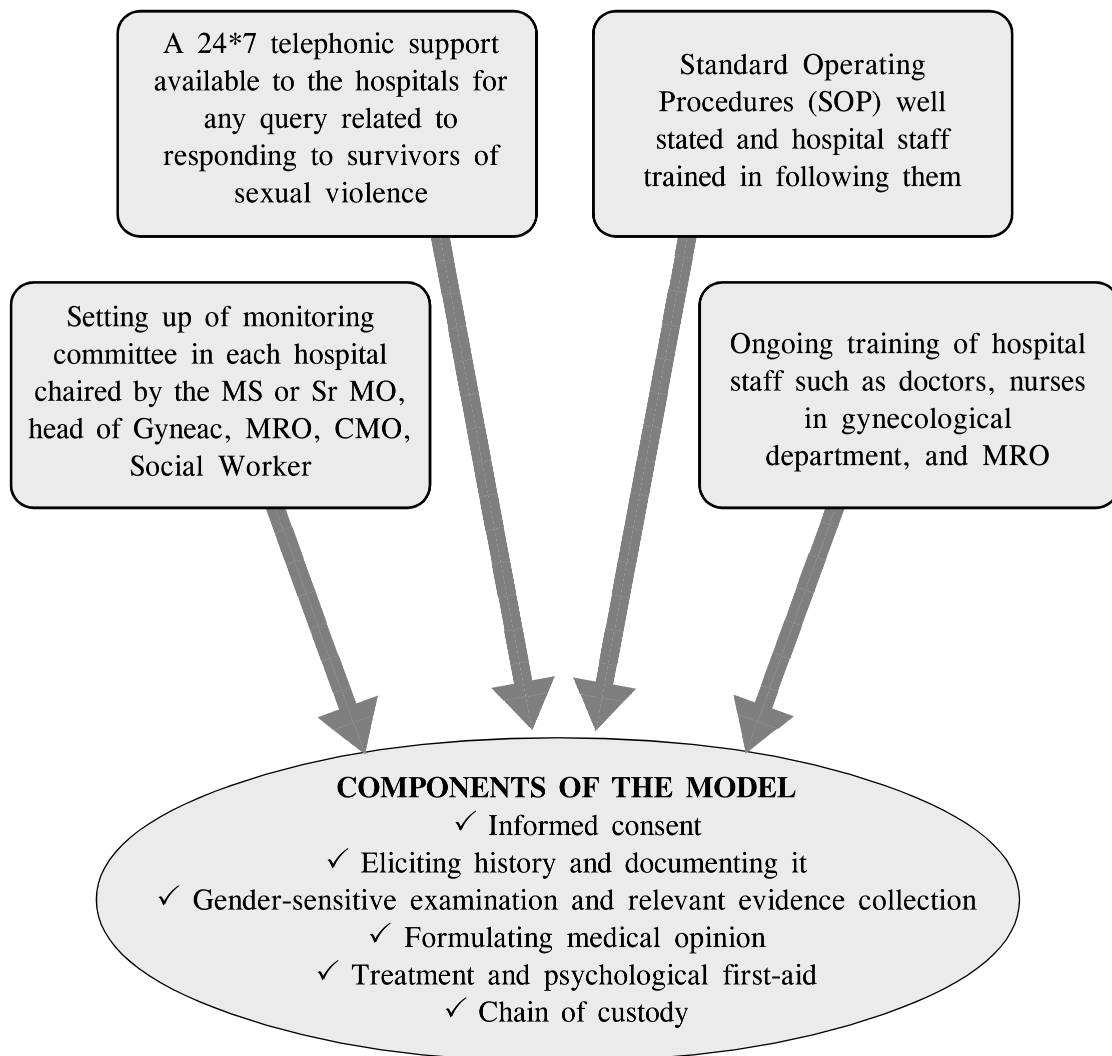
It further presents contentious issues such as implications of mandatory reporting and women reporting marital rape. The issue of adolescents' sexual rights is presented separately in the chapter on Elopement/Runaway couples. Based on the regular review of the proformas of these hospitals, the compliance to the protocol and guidelines have also been presented. The gaps in compliance have been raised in the monthly monitory committee meetings at the hospital level. The work being carried out by CEHAT and the MCGM to provide comprehensive care to all survivors of sexual violence is of significance in this context as it provides a pathway for what the MoH needs to do in terms of setting up and monitoring of services through rigourous training, hand holding and analyzing the service records.

2. Methodology

The CEHAT- MCGM joint comprehensive model for responding to sexual violence, established in 2008, is unique in many ways. It focuses on the medico-legal care and attempts to establish 'provision of care' as part of the medico-legal procedures.

The basic elements of this model are illustrated in Figure 2.1

Figure 2.1 : Components of the CEHAT-MCGM Model



The medico-legal forms of all survivors/victims registered at the three hospitals between April 2008 to March 2015 were analysed to understand the emerging patterns. These numbered 728 that had been entered into SPSS. These forms include information about sex, marital status, nature of sexual violence, health consequences, evidence collected, provisional opinion and treatment provided. Only those involved in intervention and analysis of these data, have access to this file. Some case studies are presented in later chapters but they have been written up in a way that the identity of the survivor has been protected. The CEHAT team has access to these records as part of its ongoing review and monitoring purpose. The forms are reviewed to assess if all the standards laid down have been followed. In case of any issues, these are raised in the monitoring committee and corrective action is taken.

Ethical issues

Conducting research on gender-based violence presents several ethical and methodological challenges (Kelmendi, 2013). Several issues of privacy, confidentiality and safety of respondents need to be addressed. It has been established now in the bioethics field that the consent for accessing any case records in not required as long as no identifiable information is used (Macklin, 2008). The basic principle in using case records is to maintain anonymity while reporting the information (Watt, 2006).

Our purpose in attempting an analysis of the case records is to make available information that may be of use to the police, the health systems and the courts, the stakeholders and the public in developing a comprehensive response to survivors. CEHAT is committed to bringing the survivors' voices to policy forum to inform the development of sensitive and relevant policy and programmes for survivors and their families.

CEHAT's proposal for analyzing this dataset has been duly reviewed and approved by the Institutional Ethics Committee (IEC). CEHAT has subsequently presented the analysis of the case records from 2008 to 2012 before the Justice Verma Committee in 2013, the Planning Commission and Ministries of Health and the WCD.

Case records have been analyzed to present the profile of survivors, the circumstances of abuse, the types of sexual violence reported, the pathways to disclosure, care and justice. Some issues emerging from the work being done have been highlighted, such as elopement/ runaway marriages, mandatory reporting of sexual violence by doctors and marital rape, as these have emerged sharply after the legal amendments in 2013.

3. Profile of Survivors

This chapter describes key variables based on the Medico Legal Case (MLC) records to understand who the survivors are, what complaints do they bring to the hospital, the circumstances surrounding the incident of sexual violence and the consequences on their health.

Description of cases registered as cases of sexual violence:

3.1 Age

Between April 2008 and March 2015, 728 cases of sexual violence were reported in the three hospitals under study. These are the ones where the CEHAT- MCGM is implementing a comprehensive model for responding to survivors of sexual violence. These included children, adolescents and adult women and each of these categories represent about a third of the total.

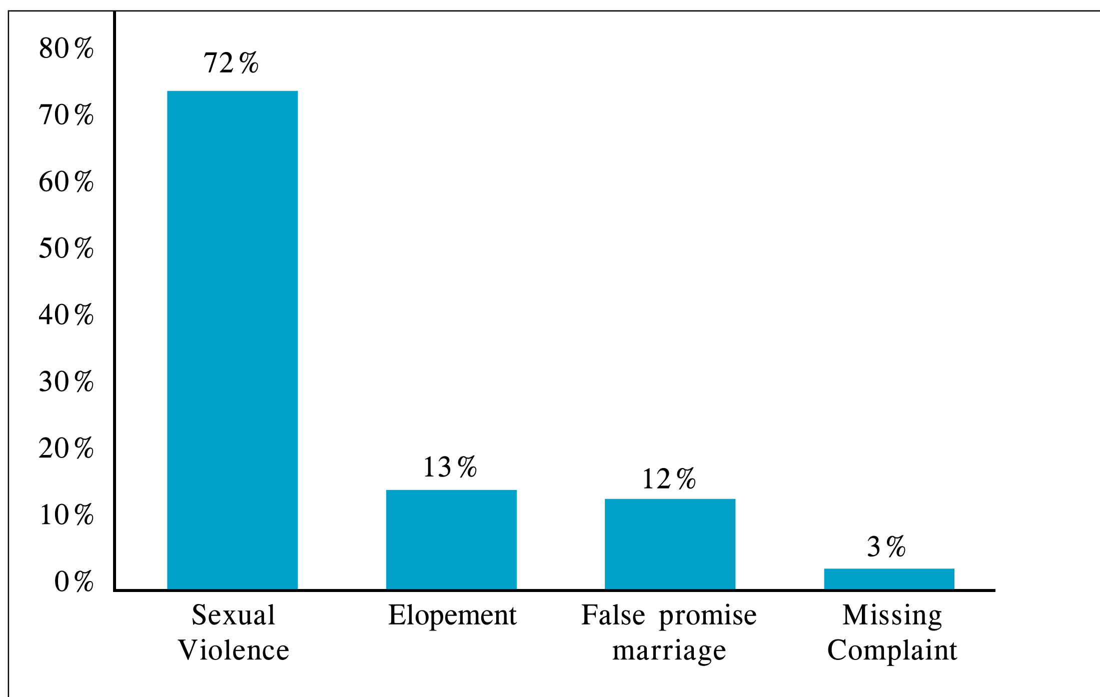
Table 3.1 : Age

	Frequency	Percent
0-12 years	237	33
13- 17 years	248	34
18 years & above	243	33
Total	728	100

3.2 Type of complaints

The 728 survivors came to the hospital on their own or were brought there by the police. All of these were recorded as 'cases of sexual violence/rape' in the medico-legal register, but the nature of the complaint varied. While 72 per cent of the cases reported incidents of sexual violence, 13 per cent of the survivors, all between 14 and 17 years, had been brought to the hospital as they had eloped with a boy; 3 per cent of the survivors had been brought in as their parents had filed a 'missing complaint' and they were all less than 18 years, and 12 per cent were those of false promise to marriage and were mostly women above 18 years. These are mutually exclusive categories.

Figure 3.1: Type of complaints



While the purpose of a medical examination in cases of sexual violence is clear, in cases of elopement it is complex as these are cases where there has been consensual sex, and in 'missing' complaints, the purpose is to "rule out sexual assault". Cases of false promise of marriage where consent for sexual intercourse has been sought with a promise to marry the survivor are defined as rape under Section 375 IPC.

3.3 Sex

Of all the survivors 98 per cent were female (girls or women), 2 per cent were males and there were two transgender persons.

Table 3.2 : Sex

	Frequency	Percent
Male	15	2
Female	711	98
Transgender	2	0.3
Total	728	100

Of the 15 males who reached the hospital with history of sexual violence, 12 were less than 12 years and two boys were between 13 to 17 years. Of the 15 males, seven reported in 2014 and the rest between 2008 to 2013. Although POCSO recognizes sexual abuse of boys, few report sexual violence. There was one boy who was more than 18 years.

Most of these male survivors reported health consequences such as bleeding/pain/fissures in the anal region which led to disclosure of the violence.

The hospitals were able to respond sensitively to them and interface with the police to ensure that the FIR was registered. The hospitals now have incorporated these as case studies for their ongoing training of other hospital staff to develop sensitivity.

3.4 Persons from LGBTQI

Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI) persons are known to suffer sexual violence but may find it difficult to access health services. In all these years only two transgender persons reached the hospitals.

The two transgender persons reached the health facility as there was severe physical and sexual abuse that required treatment.

Men also experience sexual violence but it is difficult for them to report. In the last few years, the team has documented two such instances when activists called in to inform that homosexual men were brutally assaulted and needed immediate medical treatment but were afraid of the law. Despite the team assuring them that they would facilitate the interface with the medico-legal and police system, the men did not come to the hospital.

The MoHFW guidelines are important in this regard as they clearly provide guidance on the need for doctors to respond to persons from the LGBTQI and sex workers without any discrimination. These were specifically issued in the context of health rights of these groups despite the then existing IPC Section 377 that criminalized anal and oral sexual intercourse. The staff in the hospitals therefore has been trained to be sensitive to these groups and there is an emphasis on offering privacy and confidentiality and respecting informed refusal if they do not want to register police complaints.

3.5 Persons with disability

There were nine survivors with disability including those with hearing and speech impairment (3) and those with intellectual disability (6). Pregnancy was the factor leading

to disclosure in four cases and in two, the accused was caught in the act by a family member. One was a child less than 12 years, two were 17 year-old adolescents and six were adults. In all these cases the social workers were called in to facilitate history-taking and rehabilitation. Where required, special educators were called in by the social workers.

> *22 year old G was brought to the hospital by her grandmother for abortion services at 18.4 weeks. G was mentally challenged and unable to speak properly nor pursue minimum self-care activities such as bathing and cleaning. They lived on the pavement and the grandmother was a daily wage earner who had to leave G alone while she went to earn for both of them. The girl could not say anything about what had happened. As it was not possible to identify the perpetrator in this case which jeopardised future safety, the counsellor developed a safety plan with the grandmother and approached the DWCD for ensuring shelter care for the woman after completion of treatment at the hospital.*

3.6 Marital Status

Of the cases, 85 per cent were single, large number being children; 11 per cent were married, 2 per cent were divorced, 1 per cent were separated and 1 per cent were widowed.

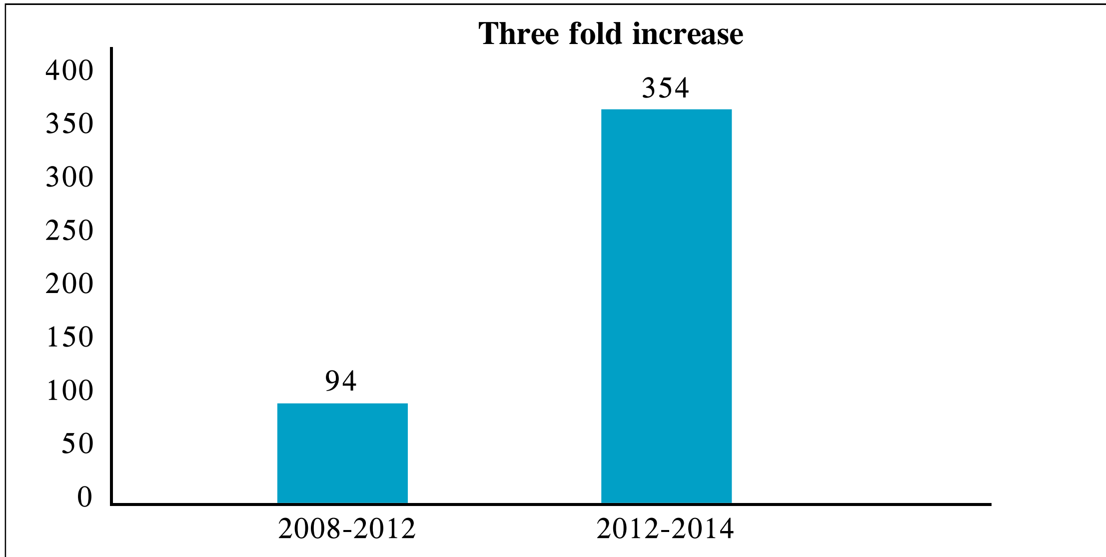
Table 3.3 : Marital status

Marital status	Frequency	Percent
Single	617	85
Married	79	11
Divorced	13	2
Separated	9	1
Widowed	10	1
Total	728	100

3.7 Impact on reported cases post 2013

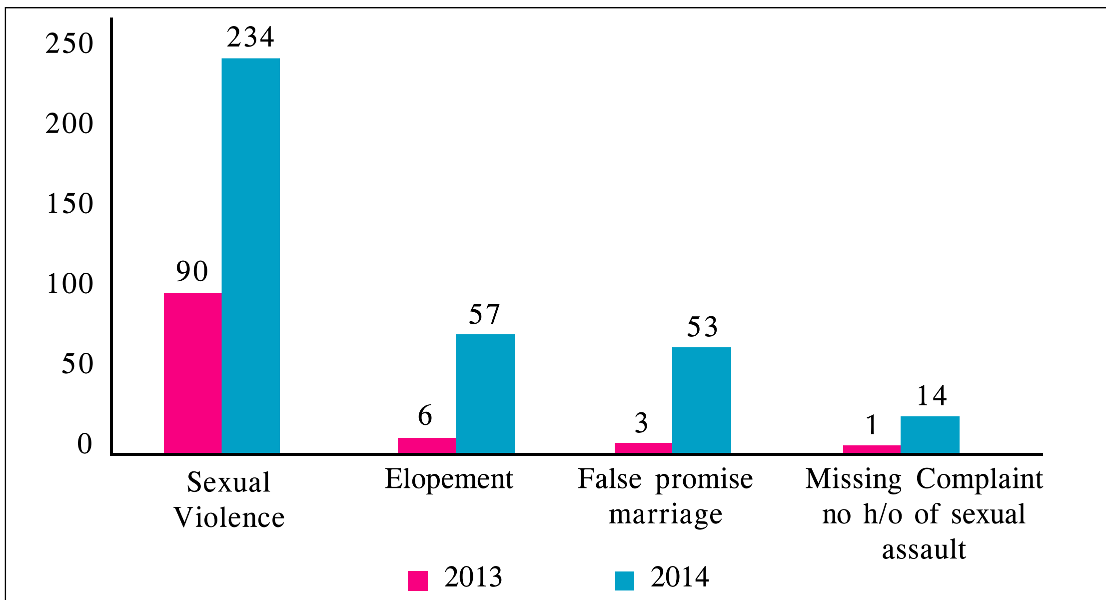
The three hospitals had received 94 cases of sexual violence between 2008 and 2012, the numbers went up three times to 354 between 2012 and 2014.

Figure 3.2 : Reported cases of Sexual Violence



Post 2013, the campaign against rape and the changes in law had a measurable and positive impact on the reporting of sexual violence. The recognition of various forms of sexual violence as rape and increased awareness about sexual violence resulted in a hike in the number of survivors reaching these hospitals. Cases of elopement showed a steep increase too as the age of consent for sexual contact was raised to 18 years in 2012 with the PoCSO Act.

Figure 3.3 : Types of Complaints



3.8 'False promise to marriage'

One of the categories of complaints, and quite contentious,is where women report that they consented to sexual activity as the man promised marriage. Under IPC Section 375 (4), a man is said to have committed rape if he has sexual intercourse with a woman "with her consent, when the man knows that he is not her husband, and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married." The accused, if proven guilty, can face a punishment of minimum 7 years in jail.

12 per cent of the all the cases seen by the three hospitals were cases of "false promise to marriage" as they are often referred to by the police and health system. These were survivors who clearly stated that they had consented to sexual relationship only on the promise of marriage. They were certain that he would eventually marry her. They had sought to file complaints of sexual assault when the promise to marry had not been honoured. Women and girls also reported being blackmailed, and/or physically and emotionally abused in such relationships. The police often invoke Section 375-4 in such cases and then the survivor is brought to the hospital for a medico-legal examination for rape. As seen from the medico-legal papers, the survivor narrates history of consensual sexual activity - it could be once or several times. It is recorded and then a detailed examination is carried out and information/treatment for any reproductive health problems is provided. As is obvious, since the woman is clearly providing a history of consensual sex, often and for a long time, the medico-legal procedure not only redundant but contributes to the case being designated a 'false case of rape', to the detriment of the women's legitimate complaints being acknowledged.

> *23 year old VD, was in relationship with a 27 year old boy and he had promised to marry her. They had consensual sex a few times in a lodge. VD did not get her periods and so when she went to the doctor, she was told that she is pregnant. She informed the boy about the pregnancy but he refused to marry her or help her in any way. Feeling desperate, VD took an overdose of 'combiflam' and 'crocin' tablets and reached the hospital.*

> *KC was in love with a colleague she met 6 years back. They worked in the same office, fell in love and he proposed to her. They had sex with her consent. He had taken some pictures and also a video of the sexual act without telling her. For the last four years, he has been threatening*

and blackmailing her that he tell her parents and put the pictures on Facebook if she does not give him money. He also has been forcing her to have sex whenever he feel wants to. He has beaten her multiple times on her face, back and abdomen.

28 year old JS was brought from her native place in a northern state to Mumbai by the accused with the promise to marry her. They lived together for a year. One day the man left home saying that he was going out for some work and did not come back. After looking for him everywhere, the women lodged a complaint.

The impact of sexual activity before marriage or with the promise to marry (consensual or forced) is always different for men and women in our society. This is due to the patriarchal society and its control over women's sexuality. Young women who engage in consensual sex face social stigma as they are expected to be virgins until they get married. Girls and their families then file rape charges as they would rather see the girls as 'hapless victims' than those with sexual agency. They see this as the only way to reclaim their place in the system of arranged marriages as they can be identified as 'virgins' who had beenraped.

Notwithstanding the social circumstances, there are several voices from women's groups and among lawyers that are against using the rape laws for such cases. These are cases of cheating and betrayal and not rape. In 2014, the number of such cases went up to 57 from a mere 6 in 2013. Pushing these cases through a rape trial is quite problematic. The consequences for the girls of not pursuing these cases are huge, and these cases may require civil remedies in terms of compensation or other.

Emerging Issues:

As described in this chapter, the hospitals receive a large number of survivors who are registered in the MLC records as "Sexual violence cases". These may be brought by police or may come directly. Of the 728 such cases registered at the hospital, 72% gave history of sexual violence where the purpose of the medico-legal examination was clear. However, the rest of the survivors gave history of elopement with a boy and some gave history of consensual sexual contact with the boy, few had been brought as 'missing', and others gave history of false promise to marriage. The medico-legal examination in these cases was carried out based on the history provided and not mechanically, thus thwarting the expectation from police and family members of 'ruling out sexual assault'. However,

this is based on good practice in these hospitals. The recent papers published in forensic journals[3] based on the medico-legal records, mention seriously problematic categorization such as "Invalid consensual sexual intercourse/invalid consensual rape, forcible rape and statutory rape, unmarried run away girls". Such categorization is not based on law or any other guidelines/policy, but the labeling is violative of girl/women's sexual and reproductive rights and also contributes to the perception of 'false cases of rape' and that 'most cases are consensual'. The health system must stop this at the earliest and categorise cases based on history provided and not judge whether it was consensual or not.

[3] S.C. Sarkar, Epidemiological Study of Patterns Sexual Offences, Indian Journal Of Applied Research, Volume 6 , Issue 7, July 2016, ISSN - 2249-555X , Sarkar, Lalwani, Rautji et al, A study of victims of sexual offences in South Delhi, AIIMS , Nanandkar S. D, Haridas, Medicolegal Study of Alleged Rape Victim Cases in Mumbai Region, International Journal of Medical Toxicology and Forensic Medicine. 2016;6(1): 12-22, Singhal A, Garg V, Yadav K, A Retrospective Study of Alleged Female Victims of Sexual Abuse, Indian Journal Of Applied Research, Volume 5, Issue 6, June 2015

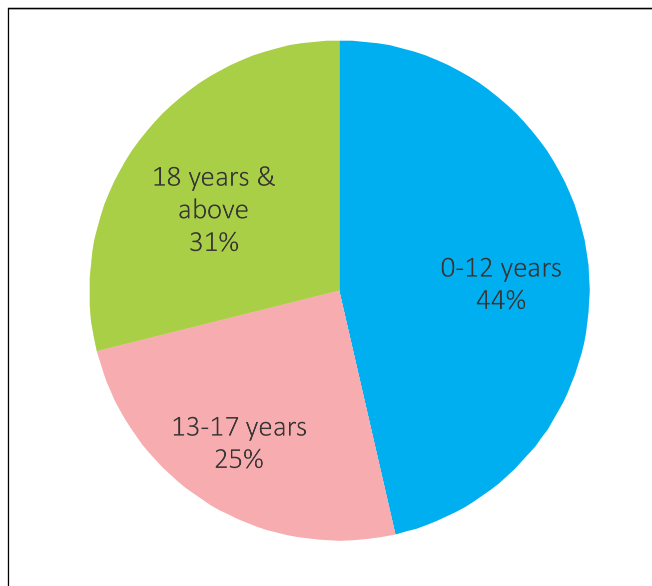
4. Dynamics of sexual violence

This chapter focuses on the data related to cases of only sexual violence, which comprise 528 of the 728 cases. The cases of elopement are described in another chapter 5.

4.1 Types of cases

Of all the cases of sexual violence complaints where the survivor has also given a narrative of sexual violence, 44 per cent were children less than 12 years, 25 per cent were between 13 to 17 years and 31 per cent were adult women.

Figure 4.1 : Agewise distribution of cases



4.2 Pathway to the hospital

It is important to understand how the survivors reached the hospital. Survivors may reach the hospital for treatment or may go to the police station to register a case and may then be brought to the hospital.Of all the cases of sexual violence, 20 per cent came directly to the hospital and 80 per cent were brought by the police. This distribution in terms of voluntary reporting vs brought by police was found to be the same across for children and adolescents, but in case of adult survivors 26 per cent came directly to the hospital and 74 per cent were brought by police. In an earlier analysis of MLC records in 2014 for the

data from 2008 to 2012, this distribution was very different. Then 44 per cent of the survivors had come directly to the hospital and were identified by doctors as having suffered sexual violence (CEHAT 2013). As the analysis is based on MLC records, it is difficult to ascertain the exact cause for this. But the most likely explanation is that there is an increase in cases being reported and registered by the police and then being brought to the hospital. These are probably the only hospitals in India where 18 per cent (131) of rape survivors voluntarily reported to the health provider. This appears to indicate that the staff is sensitized to the issue and is able to elicit history of sexual abuse and enable disclosure.

4.3 Time lapse since incident

50 per cent of the survivors reported within a day. These were predominantly children younger than 12 years. The delay in reporting is more evident among adolescents and adults. This may be because they are unable to muster courage to speak out due to fear of perpetrator or of being disbelieved.

4.4 Relationship with perpetrator

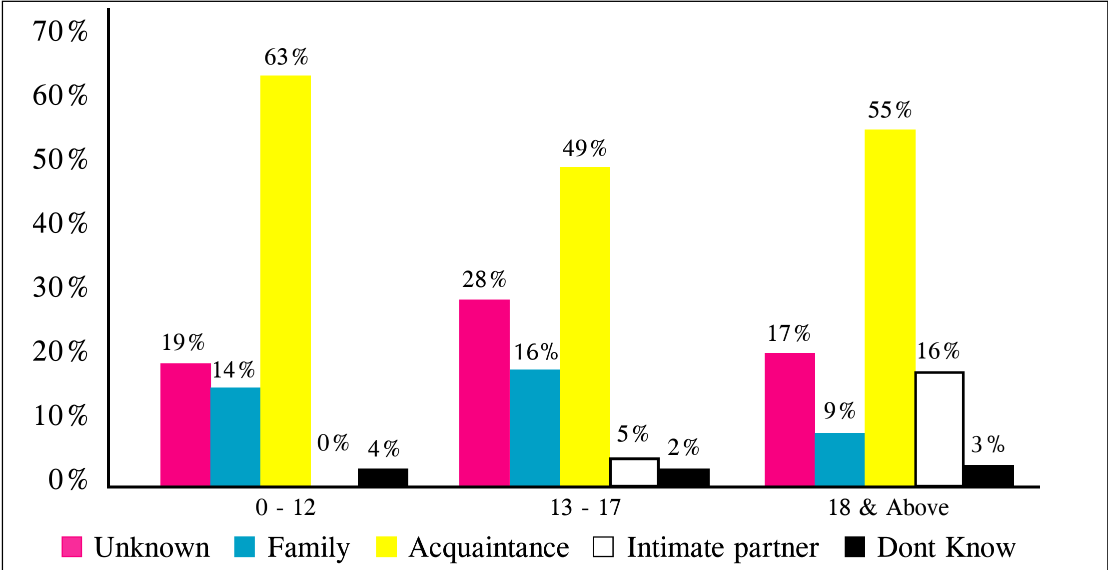
Only 21 per cent of thesurvivors were sexually abused by unknown persons or strangers. In 3 per cent of the case the survivors could not say who the abuser was. In the rest of the cases, a large 79 per cent, survivors were abused by known person (57 per cent were known persons such as neighbour, teacher, shopkeeper and so on, 13 per cent were family members and 6 per cent were abused by intimate partners). The NCRB data too showed that a whopping 93 per cent of the offenders are known to the victims/survivors to some extent.

Table 4.1 : Relationship with perpetrator

	Frequency	Percent
Unknown	110	21
Family	69	13
Acquaintance	301	57
Intimate partner	32	6
Don’t Know	16	3
Total	528	100

The relationship with perpetrator across age categories provides some more insight into sexual violence. Amongst children under 12 years, the perpetrator was a known person in 63 per cent of the cases; in 14 per cent of the cases it was a family member, and 19 per cent cases the abuse was by an unknown person. Amongst adolescents between 13 to 17 years of age, 49 per cent were known to the survivor, 28 per cent were unknown, 16 per cent were family members and 5 per cent were intimate partners. In case of adult women, 16 per cent of the survivors were abused by intimate partner, 55 per cent were known to the survivor, 9 per cent were family members and 17 per cent were unknown.Family members included father, step father, uncle or brother.

Figure 4.2 : Relationship with perpetrator across age of survivor



Age of the perpetrator

88 per cent of the perpetrators were adults, 8 per cent were adolescent boys and in 4 per cent of the cases, the age could not be ascertained

4.5 Location of the incident of sexual violence

Of the survivors, 26 per cent reported that they were abused in their own home and 27 per cent reported that the incident took place in the assailant's house, thus breaking the myth of homes being safe. Most incidents of sexual violence occur in the homes as the perpetrators and are mostly people known to the survivor-either family or a neighbour or a friend.

PS had gone to stay with her aunt when her uncle came to her room at night. She was sleeping when he put his hand in her panty and tried to put his finger in her vagina. He also pressed her breasts. He tried to make her sit on his lap and remove her clothes when he heard some sound. He tried doing this again when she screamed and told her mother about it.

Another 27 per cent reported that the incident took place in the area surrounding their homes. Only 7 per cent said that it took place in an isolated area. 4 per cent said the incident took place in a hotel. 3 per cent were abused in the school/college, 1 per cent were abused at their workplace, and 2 per cent were abused during travel in an auto/bus/ train.

Table 4.3 : Location of incident of sexual violence

Location of incident of sexual violence	Frequency	Percent
Survivor's house	138	26
Assailant's house	142	27
Surrounding area of home	141	27
Unknown isolated area	37	7
in the school / College	14	3
Hotel	22	4
Unconscious so history not clear	4	1
Survivor's workplace	4	1
During journey in train/bus/school van/car/rickshaw	13	2
Don't know	13	2
Total	528	100

4.6 Past history of abuse

Nearly a quarter of the survivors (24 per cent) reported that they had been abused in the past by the same abuser. While there are clearly barriers to survivors reporting past abuse from a known person, that the majortiy of the survivors (76 per cent) reported the very first time the abuse took place is significant.

Of the 129 survivors who reported some form of past abuse 59 (46 per cent) were adult women, 34 (26 per cent) were adolescents and 36 (28 per cent) were children under 12 years. Among adult women, it was the abuser was an intimate partner - husband or boyfriend in 21 cases. The intimate partner had repeatedly used physical violence and

threats that prevented the survivor from speaking out. Among a large number of adult survivors the perpetrators were acquaintances and the pattern of abuse included the use of threats or blackmailing her over a nude photograph or video that the abuser had taken in the first incident of sexual violence.

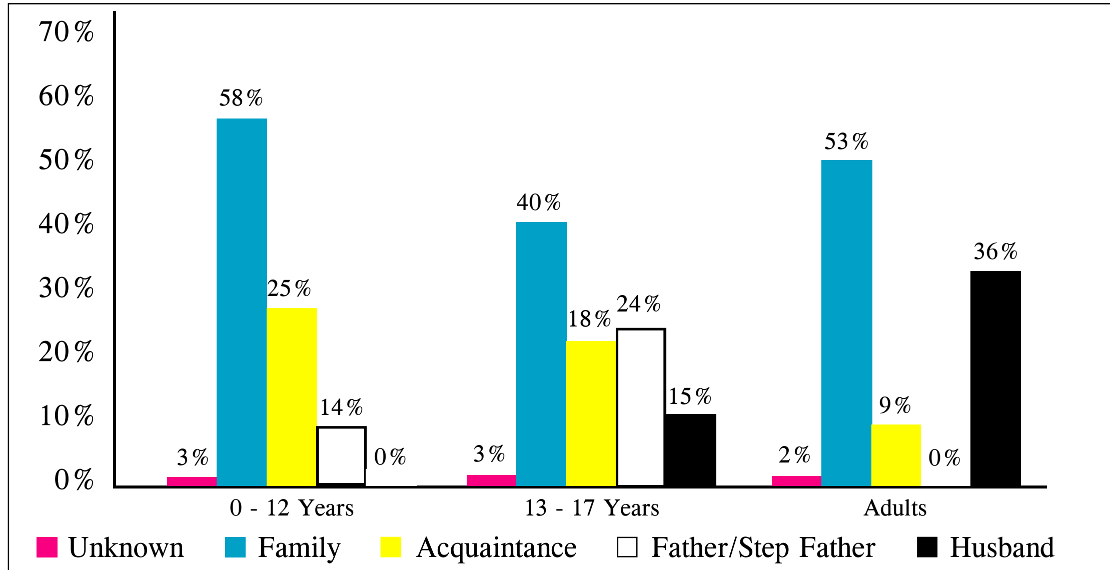
In 13 cases of children and adolescents, it was the father or step father who had repeatedly abused the girl. Chronic abuse by father/ family member/acquaintance is difficult to report due to fear and the close relationship. It also has a long term psychological and physical health consequence.

> *MT 8 years old slept with her mother and father on a mattress at home. The mother noticed that the father was lying on the survivor and her pants had been partially pulled down. The father got up at once. The mother noticed wetness around the girl's genitals. She decided to report to the police as she had noticed similar incident few weeks back.*
>
> *VS is a 14 yr old who disclosed that her father had raped her several times in last three months. He had threatened her that he would kill her mother if she revealed it to anyone.*
>
> *RD aged 14 years has been abused by her step-father for 3 years in the absence of her mother. Whenever she tried to resist or stop him, he would throw things at her and threaten to kill her and her mother. He had also clicked her nude photographs and would threaten to show them to everyone. RD finally gathered up courage and told her mother.*

The large number of children and adolescents disclosing abuse by father/family member/ acquaintance immediately after first incident could be considered as a good sign of increased awareness that such behaviour is wrong and must be reported. The hospitals have seen an increase of such cases over these years.

In case of stranger/unknown person the past abuse was in the form of touching and/or physical abuse.

Figure 4.3 : History of Past abuse - Age of survivor and relationship with perpetrator



4.7 Circumstances surrounding the incident

35 per cent of the survivors reported the assault immediately, 20 per cent reported the incident when they were threatened or abused again, in 14 per cent of the cases health complaints led to disclosure, 15 per cent were caught in the act by a family member or neighbour.

Many survivors of all age groups have reported incidents such as abuse in public toilets, by lanes of the slums, being pulled into a known person's house in their descriptions of abuse. They have told someone within a day of the incident despite the fear and humiliation.

> *5 yrs old BC had gone to the public toilet with her mother. The mother went home to get water in the bucket (house is close by) When the mother came back with water, she found a 18 year old neighbour standing near the toilet. He ran away on seeing her. When she asked BC what he was doing, the girl reported that he came inside the toilet and put his hand in her vagina.*
>
> *AD is 7 years and was sleeping in her house when the man entered her house, took off her panty and licked her genitals. AD woke up suddenly and he ran away. He came back to house after 5 minutes to ask for tobacco. On seeing him, the girl started crying and narrated the incident to her mother.*

11 per cent of the survivors reported that they were drugged/intoxicated. Of these 58 survivors, 31 were adult women, 23 were adolescents and 4 were children.

FS went with her friend to her house where was offered something to drink. She soon started feeling dizzy and lost consciousness. Next morning she woke up and found herself naked. When she asked the man sitting in the room, he threatened to leak a video recording of the girl if she complained. She was repeatedly raped for a week. When her parents filed a missing complaint, the man left her at the police station. The girl did not reveal anything due to fear. But later when she had pain in abdomen, she told her mother what had happened.

Overall, 40 per cent of the survivors reported some form of threat by the perpetrator, verbal or physical such as harm to their harm to the survivor and/or family member, posting video/photo on social media, threat to life amongst others. 30 per centsurvivors reported verbal threats and abuse and 4 per cent threatened with weapons. 24 per cent reported past physical and/or sexual abuse from the perpetrator.

17 per cent said that they had been lured with chocolate or sweet and most of them were children. Only 13 per cent of the survivors were able to resist either by screaming or running away, while 10 per cent reported fighting by pushing or scratching. A large number of survivors, 76 per cent reported that they were unable to resist as they were rendered helpless by drugging or were unconscious or sleeping, were physically restrained, threatened or due to disability or being too young to offer any resistance.

Table 4.4 : Resistance / lack of resistance

Resistance / lack of resistance	Frequency	Percent
Resisted by screaming / running away	68	13
Resisted by fighting(pushing away, scratching)	50	10
Unable to resist because physically restrained	74	14
Unable to resist because drugged/unconscious/sleeping	50	10
Unable to resist due to threats/fear	128	23
Too small to understand / resist / mentally challenged	154	29
Unconscious so history is not clear	4	1
Total	528	100

A large number of survivors reported activities leading to loss of evidence. 79 per cent had voided urine, 66 per cent had eaten food, 68 per cent had ingested fluid, 63 per cent had changed clothes, 56 per cent had defecated, 56 per cent had taken a bath and 40 per cent had douched. Often survivors have said that first thing that they did was to clean themselves and mothers too have said that they first cleaned the child and checked if she was okay.

Table 4.5 : Activities Leading to Loss of Evidence

Nature of Activities	Frequancy	Percent
Voided Urine	406	79
Eaten Food	346	66
Ingested Fluid	356	68
Changed Clothes	330	63
Defeacted	306	56
Bathed	288	56
Douched	206	40

6 per cent of the survivors reported use of condom but 24 per cent could not provide any information about whether condom[4] was used or not. 5 per cent survivors reported use of lubricant.

All these have implications on the medical evidence to be collected, as no forensic evidence is likely to be found on the body.

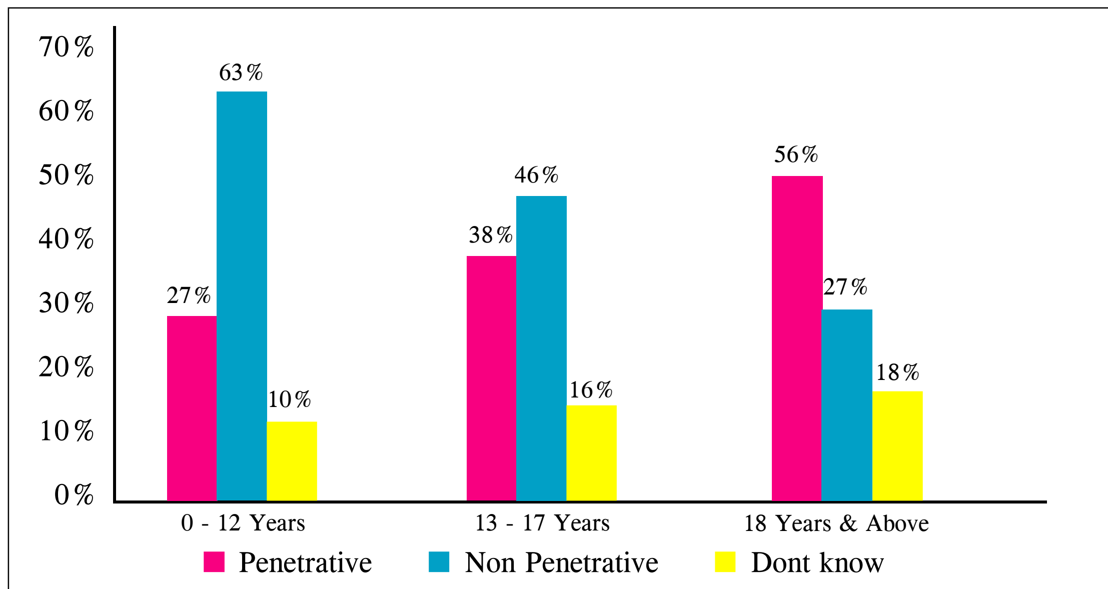
4.8 Nature of sexual violence

The nature of sexual violence or form of sexual violence has implication for the nature of examination, the evidence to be collected and the health consequences for the survivor. 39 per cent of the survivors reported penetrative assault and 48 per cent reported non-penetrative assault. 13 per cent of the survivors were not able to state the nature of assault. Penetrative assault included peno vaginal penetration, penetration of vagina by finger, peno-anal penetration, penetration of anus by finger, and two cases of penetration of anus by object and penetration of mouth by penis. Non penetrative assault include,

masturbation of perpetrator, kicking, sucking, licking of breasts/lips, attempted penetration by finger.

Amongst children under 12 years, 27 per cent reported penetrative assault and 63 per cent reported non-penetrative assault. Amongst adolescents 38 per cent reported penetrative and 46 per cent reported non-penetrative assault. Amongst adult women, 56 per cent reported penetrative assault and 27 per cent reported non-penetrative assault. The fact that so many children and adolescents spoke up in cases of non-penetrative assault is a good indicator of high awareness within society. As most of these were brought by police, it is a sign that the police too are registering such cases.

Figure 4.3 : Nature of sexual violence and age of survivor



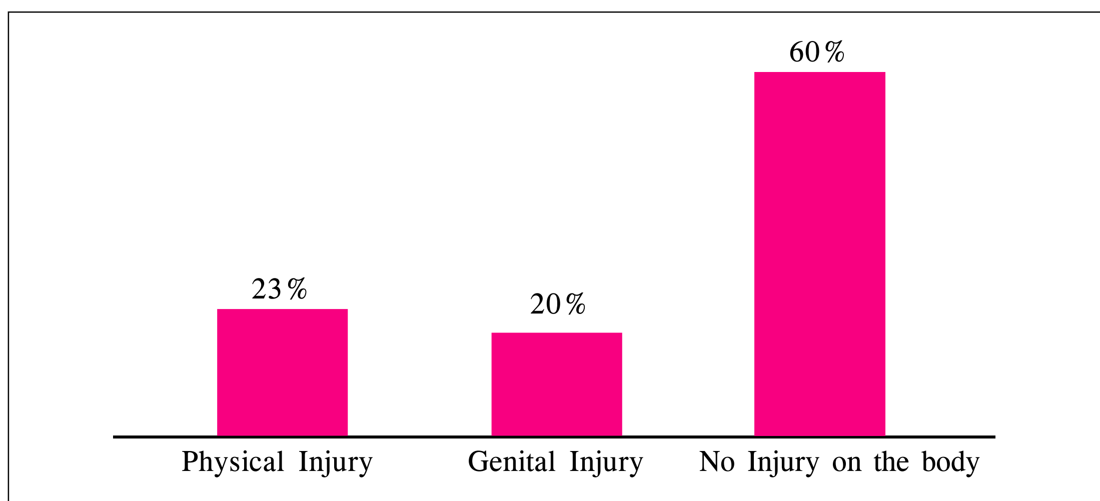
4.9 Health consequences

Every form of sexual violence has health consequences, physical and/or psychological. There is a strong perception amongst health providers and people at large that all rape survivors must report some form of injury as there is 'force' involved. However, health consequences of sexual violence go beyond injuries such as pain and sexually transmitted infections. Overall, 48 per cent of the survivors reported some form of health consequence- either an injury and/or a health complaint. Amongst those who reported a health consequence, most of them, 64 per cent reported penetrative sexual assault and 36 per cent reported non-penetrative sexual assault.

In the 528 cases under analysis here, 79 per cent of the survivors did not require any hospital admission, while 6 per cent (30) were admitted for a week, 11 per cent (57) for 2-4 days, and 3 per cent (14) for a day.

Based on the analysis of MLC records, 40 per cent of all survivors reported physical and/ or genital injury. 20 per cent survivors reported genital injury and 23 per cent reported physical injury. Of those who reported an injury, 44 per cent were children, 36 per cent were adult women and 20 per cent were adolescents. The rest of the survivors had no injuries on their body. The nature of the injury reported were abrasion, tenderness, bruise, scratch and swelling.

Figure 4.4 : Types of injury



The lack of injuries needs to be interpreted in the context of the nature of assault, whether it was penetrative or non-penetrative, history of drugging, use of threats or inability to resist.

Of those who suffered some form of health complaint, 7 per cent (35) reported vaginal discharge, 5 per cent (25) reported pregnancy, 6 per cent (30) reported pain in body parts, 5 per cent (26) complained of pain in genitals, 4 per cent (23) reported burning micturition, 2 per cent (12) reported pain in rectum and 2 survivors reported anal discharge (Table 4.5). These are all consequences of sexual violence and need to be recognised as evidence in these cases.

Table 4.5 : Type of Health consequences

Health consequences	Numbers	Percentage
Vaginal Bleeding	58	11
Vaginal discharge	35	7
Pain in other body part	30	6
Pain in genital area	26	5
Pregnancy	25	5
Burning micturition	23	4
Anal bleeding	16	3
Pain in rectum	12	2
Anal discharge	2	0.4

Multiple response

Of all the 728 survivors that the hospitals responded to, 43 survivors reported pregnancy as outcome of rape, 29 underwent an abortion and 2 chose to have the abortion elsewhere. 12 had reported after 20 weeks of gestation and so they were denied abortion as per the law.

5. Elopement/Runaway Marriages

There is a strong perception that the majority of rape cases are cases of consensual sex which refer to cases of elopement or runaway marriage. This perception had been further compounded by some reports based on analysis of court judgments that have highlighted that 40 per cent of cases were from this category, such as the study undertaken by The Hindu[5] in Delhi. What this implies is that most cases of rape involve "consent by girl/ woman for sexual intercourse". Elopement or runaway marriages refer to cases where the couple has eloped in the face of strong opposition to their relationship that may be because of caste, religion or class differences. Typically, girls' families resort to filing case of kidnapping and/or rape against the boy. Recent changes in law have further complicated the manner in which these cases are handled.

At the three hospitals, 90 (13 per cent) were cases where survivors said that they had eloped with the boy. This situation is further complicated now with the POCSO 2012 which defines a child as any person under the age of 18 years and raises the age of consent for sexual contact to 18 years, thus criminalizing any consensual sexual act among adolescents. As per the law all such cases have to be mandatorily reported to the police as cases of sexual violence. This violates the right to bodily integrity and sexual rights of adolescents and pushes them into a criminal justice system without their consent.

In the following sections, the data from the records has been analyzed to present the circumstances under which the incidence was reported, the role of the hospital, the police and the family.

5.1 Profile of adolescents

The majority of the adolescent girls (60 per cent) who reported that they had eloped were 16- 17 years old; 40 per cent of the girls were 13-15 old, the youngest being 13 years old.

Of all the girls who eloped, only 22 per cent (16) reported that they had married their partners in a temple or masjid after running away from home. Most of these (69 per cent) were 17 years old. We add a note on the social context of these cases here. Arranged marriages of legally underage girls are endemic in the country, and these are hardly ever

[5] https://www.thehindu.com/data/the-many-shades-of-rape-cases-in-delhi/article6261042.ece

brought before the courts of law. The reason why the cases under discussion do come to the attention of the police is because parents regard such elopements as bringing 'disrepute' to their families and use the law to redeem the situation.

5.2 Interface with the hospitals

All the 90 girls were brought to the hospital by the police for the purpose of medico-legal examination as the girls' parents had filed cases of rape. The girls had run away from their homes, following which the parents had filed what is called "missing complaint" so that the police could search for them. When the girls were found, they were brought to the hospital for medical examination as they suspected sexual violence. In such cases,the girls may be found 5 days or even 2 years after they went missing.

> *17 year old A, was brought by police to the hospital and gave history of running (away) with her boyfriend 2 years ago. They went to some other state and lived together in a rented house. After two months, the girl got pregnant and registered herself for antenatal care in a nearby hospital. When she was 8 months pregnant, she got married with the same boy by using fake documents. Her parents had filed a missing complaint 2 years back and the police found them now and brought the girl, her husband and 5 months old daughter to Mumbai. As per procedure they brought her for a medico-legal examination of rape!*

The above example has been selected to highlight the ridiculousness and futility of this exercise. As this is a criminal case and the survivor is brought by the police, the entire medico-legal procedure to be carried out for a rape survivor has to be followed for her too. For other survivors too, going through the entire procedure is an ordeal. When doctors ask the girl to narrate the incident of sexual violence and the girl actually describes running (away) from home and consensual sexual contact, it is ridiculous to expect the doctor to conduct the entire procedure of a complete body examination and evidence collection.

According to law, parent/guardian's consent is required; but the three hospitals adhere to the MoHFW guidelines and protocols that allow all above 12 to give consent for medico legal procedure. In practice, the majority of the girls were empowered to record their refusal to the procedure by clearly stating that they had run away and did not want an examination or forensic evidence collection. Their wishes were respected by these hospitals.

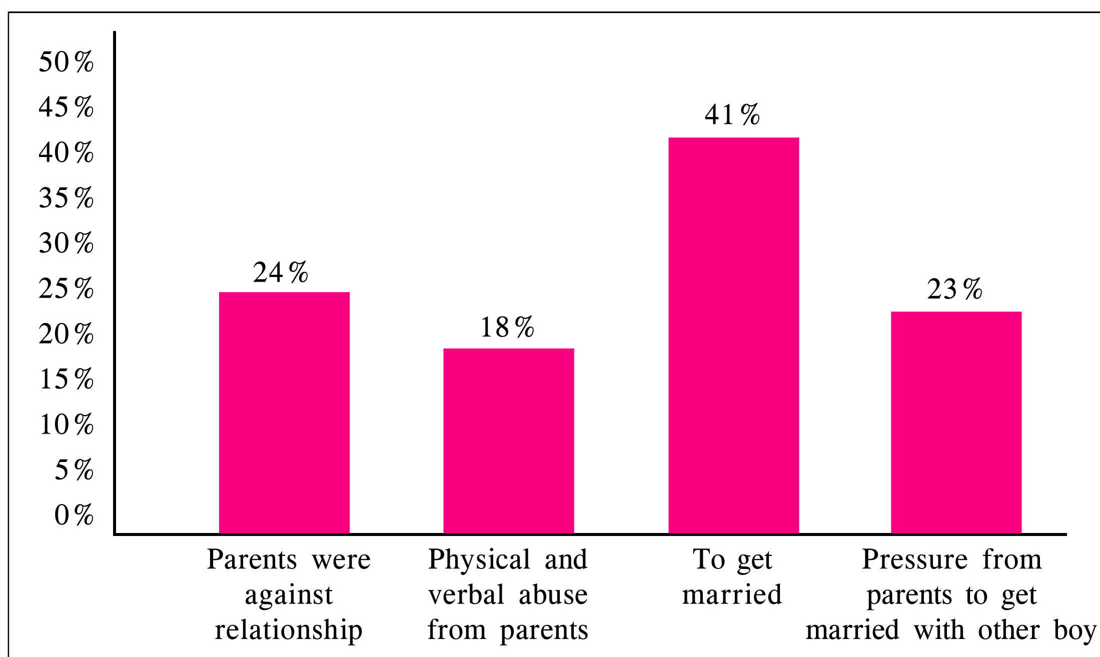
5.3 Reasons for elopement

The girls were able to provide detailed account to the doctors. 41 per cent reported that they had run away with the boy as they wanted to get married and there was opposition from their parents. 24 per cent girls said that they had run away because their parents did not approve of their relationship. 23 per cent of the girls said that they ran away as their parents were forcing them to marry some other boy. 18 per cent girls said that they were facing physical and mental abuse in their parental homes and so they ran away.

> *A 16 year old adolescent girl left home to commit suicide because of chronic physical abuse from her grandfather and brothers. When her boyfriend came to know about this, he found her with help of their common friends. They eloped and started cohabiting together in another city.*

28 per cent of these girls said that they did not want to go back to their homes because of the fear of house arrest and asked counsellor for shelter services. The girls confessed to both the counselor and the police that they were afraid that they would be confined to their homes by their families with severe restrictions on their movements, and that they would be forced to discontinue school/college, with their worst fear being that they would be forced to marry someone soon.

Figure 5.1 : Reasons for Elopement



5.4 Consent for evidence collection

Hospitals follow due process of seeking informed consent, which in practice means that they are told about the purpose and procedure of the medico-legal examination and evidence collection, and treatment. The survivor's consent or refusal for every part is sought and respected. The information provided is related to the purpose of the medico-legal procedure which is mainly to document the incident/s of sexual violence, and collect any medical evidence from her body so that the perpetrator can be punished.

About 51 per cent of the adolescent girls brought to the hospital for medico-legal examination refused to allow evidence collection after they were told of its consequences. In five such cases where the girls refused the procedure, the police brought them back to the hospital after a day or two following pressure from the family.

But the rest of the girls consented to undergo the procedure under pressure from family members. The girls spoke about the various pressures, fear and threats from their parents which included threat to discontinue education, being sent away to a relative's house in their native village or even be forced to marry someone of the family's choice.

But all the girls who consented to the procedure told the doctors, as part of the narration of the incident, that they went of their own free will and that their boyfriends had not coerced them.

5.5 History of sexual contact

The girls clearly told the doctors that they had run away of their own free will and that the sexual contact/s was consensual. More than two-third (77 per cent) of these adolescent girls reported having consensual sexual relationships. Contrary to popular belief that all those who elope have had sex, 22 per cent of the girls reported that they did not have sexual intercourse and reported kissing, touching and fondling. This is important to note as adolescents are exercising their sexual rights and they must be recognised as persons with sexual agency. There is a growing acceptance of this but the law makes all such consensual relationships under the age of 18 years a crime. Girls as young as 14 years also spoke about engaging in healthy consensual sexual relationship.

5.6 Reproductive health

8 per cent of the girls were pregnant when they were brought to the hospital. They did not want to continue pregnancy and wanted an abortion as they did not want a child so early

in their married lives. Three of them were offered abortion services after the medico-legal procedure was completed. Those who reported after 20 weeks of pregnancy could not be offered abortion as per the MTP law. The delay in reaching health service for an abortion is due to various reasons especially lack of information about contraception and taboos around sex which prevent them from accessing any service or information about safe sex and ways to prevent a pregnancy. Many girls in this age group are unaware that sexual intercourse may lead to pregnancy.

Only 10 per cent of the girls reported using contraception, which was mostly use of condoms.

Access to abortion was not easy to get. Under the current legal provisions under POCSO the hospitals have to mandatorily report all cases of sexual contact for girls under 18 years of age, be it consensual or non-consensual, to the police. Girls who only want an abortion are asked to file a police complaint first, even though they clearly without coercion say that the sex was consensual. This forces them to leave the hospital, having been denied abortion.

5.7 Barriers in accessing health care

> *A 17 year old girl who was 18 weeks pregnant came to hospital with her mother for abortion. She clearly told the doctor that the pregnancy was the result of the consensual relationship with her boyfriend. She said that she did not want to file a police complaint. The girl was told that the hospital will have to inform the police as per POCSO .*

FIR was lodged after 5 days when girl first came to hospital for abortion. After 3 days of FIR, police brought her to the hospital for medico-legal examination. The girl refused medical examination and consented for the treatment. Finally, the girl received the abortion 8 days after she had initially come to hospital with her mother.

As illustrated above, if girls do comply with the mandatory reporting law in order to get access to abortion, the process could take time. As seen here, the girl was already in her 18th week when she first came and by the time she actually got the abortion it was 20th week very close to the gestational limit under the MTP Act.

While this indicates the barriers at institutional level, the following case study illustrates how the family, and institution can make the situation difficult for young women. Parents of young girls who exercise their sexual rights are so enraged that they can go to any

length to punish their daughters by locking them up, sending them to shelter homes, forcing them to marry. The act of exercising her choice to seek her own intimate partner is seen as transgression and loss of honour. Others have documented honour killings in inter caste/inter religious marriages.

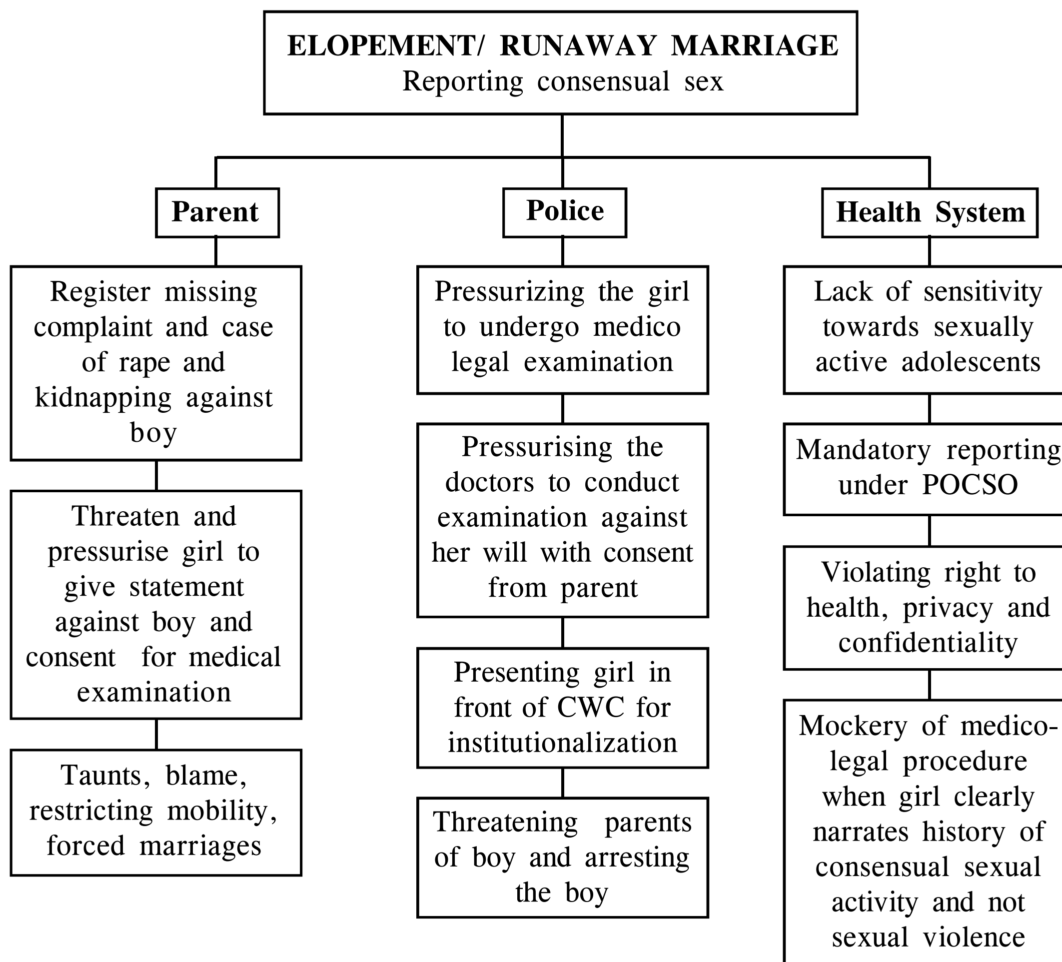
A 15 year old girl fell in love with a 22 year old boy and started living together. The father of the girl filed a missing complaint. The police caught the couple and brought them to the police station. The boy was arrested. The girl was sent to shelter home by father so that she doesn't run away from home again. As per POCSO, the girl was brought to hospital for a medico-legal examination. The father revealed to the doctor that the girl is 10 weeks pregnant. The girl told doctor that she wants an abortion and maintained that she went with the boy on her own will and there was no coercion. For MTP, the written consent of father was required as the girl was below 18 years of age. The father refused to give consent by saying that "if she had an abortion, she would repeatedly run away and get pregnant". Counsellor spoke to father of girl and emphasized the fact that the physical health of girl is very poor and that the going ahead of pregnancy could be fatal. The girl's father finally agreed for MTP on a condition that the products of conception (POC) from the abortion were given to the police for DNA examination as evidence to strengthen the case for rape against the boy. The girl was informed by doctor and counsellor that after MTP she can give a written statement that she doesn't want any medico-legal evidence to be sent for forensic investigation. Despite the efforts of the doctor and counsellor, girl was pressurised by father and the police to give consent for dispatching POC to forensic lab.

The above two cases as well as the narrations of the other girls who had eloped raises several pertinent questions, the most significant being, whether adolescent girls can exercise their right to health care.

5.8 Precarious situation for the young couple

The runaway/elopement couple find themselves in a precarious situation. The girl has to deal with threats and pressures from the family, the police and the health system. Each of these are hostile and insensitive to what the girl and boy are narrating. The issues with each of these are presented in Figure 5.2 to illustrate the tensions that they have to deal with.

Figure 5.2 : Interface with parents/health and police



The family registers a complaint with the police stating that their daughter is missing and also allege that she has been kidnapped and raped by the boy. Once the couple is found, the family pressurizes the girl to give a statement against the boy for having kidnapped and raped her. They also force the girl to undergo a medical examination so that there is medical evidence against the boy. Irrespective of what the girl says the boy is arrested as it is a case of rape. The girl finds herself really vulnerable as her family taunts and threatens her. We found that most girls were courageous enough to tell the doctor that they had run away and had not been kidnapped and that they had had consensual sex.

In all such cases, the police was found to be proactive. They bring the girl to the hospital and pressurize her and the doctors to conduct a medical and forensic examination against

her will, with the consent of the parent. The girl is then presented before Child Welfare Committee (CWC) for assessing the need for institutionalizing her.

At the level of the health system, there is lack of sensitivity towards sexually active adolescents. The mandatory reporting under POCSO poses a major dilemma as the girls clearly state that they have not been sexually abused. The entire medico-legal procedure is a mere drill and mockery as there is no history of sexual violence.

Despite a statement of consensual running away/elopement and consensual sexual activity by the boy and girl, the entire mechanism operates as per procedure for 'rape' thus making a mockery of the entire process.

Emerging Issues:

Contradiction between POCSO and the Rashtriya Kishor Swasthya Karyakram (RKSK) programme.

The law has raised the age of consent to 18 years thus criminalizing all sexual activity amongst adolescents as rape. This is contrary to what is now well evidenced that the key to encourage responsible sexual behaviour among adolescents is to provide sex/sexuality education. But any discussion about sexuality education and contraception with adolescents is controversial.

The RKSK programme[6] and all its related documents present a rights based approach to adolescent sexual and reproductive health as per global standards. The programme also encourages setting up of adolescent clinics for sexual and reproductive health information. But young people accessing such services could be pushed into the criminal justice system if they reported any consensual sexual activity! Young adolescent boys can be criminalised for consensual sexual relationship. If the boy is under 18 years he can be convicted for rape. If he is tried as an adult he will have a criminal record for the rest of his life even though it was a consensual activity. If he is tried as a juvenile he goes to a correction home for detention!

This clearly points to the dichotomy between the law and the health programme and points to the urgent need to speak to adolescents about sex.

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[6] Objectives of RKSK include 1.Improve knowledge, attitudes and behaviour, in relation to SRH, 2. Reduce teenage pregnancies 3. Improve birth preparedness, complication readiness and provide early parenting support for adolescent parents

Mandatory reporting by health professionals:

In addition to criminalizing all sexual activity among adolescents, the law also makes it mandatory for health professionals, including counselors, to report to the police immediately. This poses a major barrier in access to health care including safe abortion for young girls.

Role of health providers:

How should health providers balance their obligation to provide treatment, respect the autonomy of the adolescents and also fulfill their legal responsibilities? As per the MTP Act, the consent for abortion has to be sought from the parent or guardian. The doctors therefore need to be skilled and willing to engage with the parent/guardian and explain issues related to sexual and reproductive health of the young girls.

The POCSO directly contravenes the sexual and reproductive health rights of adolescent recognized under RKSK by criminalizing all consensual sexual contact between them. An unwanted pregnancy in such circumstances can create a major havoc not just in the life of the girl but also the boy as he is arrested and the Product of Conception (PoC) becomes a piece of forensic evidence to nail him down.

Selective and overactive legal/police system:

Families routinely marry their daughters before they turn 18 years despite the law against child marriage. The response of the police and their selective implementation of law is obvious in the cases of elopement as against their inaction in stopping child marriages.

6. Contentious Issues: Mandatory Reporting to Police

One of the challenges posed by the recent changes in laws related to sexual violence is the additional responsibility for health professionals of mandatory reporting to the police of all cases of sexual violence. Section 19 POCSO Act and Section 357 C Criminal Procedure Code (CrPC) instruct the doctor/hospital to mandatorily inform the police when they identitya case of sexual violence. Section 21 of POCSO Act and Section 166 B IPC (Indian Penal Code) further prescribes punishment for not doing so. This creates a peculiar situation as the law makes it mandatory to provide treatment and report to the police. Health care professionals are faced with an ethical dilemma when survivors do not wish to report to the police. They are caught between their legal responsibility of reporting the crime and the likelihood of survivors leaving the facility without treatment, amounting to denial of treatment.

It is a known fact that there is a gap between actual incidence of sexual violence and what gets reported. There is also a difference between what is reported by survivors and what gets registered by the police. Notions of shame and honour associated with rape often prevent survivors and their families from divulging the crime. The insensitivity and long delays of the criminal justice system also deter survivors from reporting the crime to the police.

In consequence, mandatory reporting to police discourages young girls and women from seeking sexual and reproductive health care services. It is important that survivors speak out, receive necessary care and support to cope with the trauma and other health consequences. But they may not want to pursue the case.

This situation is not unique to India. In the United States, for instance, Violence Against Women Act, (VAWA) has undergone several amendments and some states have expanded mandatory reporting beyond intimation to law enforcement agencies alone. The state of Kentucky mandates reporting to the Adult Protective Services instead of law enforcement agency. In fact in Kentucky, it is the social worker and not the police that contacts the survivor. The survivor is offered appropriate social or/and legal services and the course of action is determined on the basis of a dialogue with the survivor. The Kansas State Domestic Violence and Sexual Assault Support Programme has laid down a model policy regarding mandatory reporting. The policy states that the decision of reporting to law

enforcement agencies or to social and rehabilitation services lies with the survivor. The policy also states that specific personnel directed by the VAWA to mandatorily report cannot dismiss their responsibility by merely intimating the police machinery and that their responsibility extends to providing psycho social interventions and putting survivors in touch with appropriate support agencies (Pickert, 2013).

The three hospitals have established protocols for dealing with specific issues arising out of this legal obligation to mandatorily report to the police. Survivors have to formally consent to the police being informed. In most cases survivors and their families do wish to report. But in some cases they do not want to make a police complaint, but need treatment. With the intention to not deny them their right to treatment, the hospitals register a medicolegal case and inform the police that the survivor does not wish to file a police complaint. Thus, registering an MLC has been recognised as complying with the mandatory reporting clause.

Based on the service records and the interventions by the team, the next sections describe various compelling circumstances that survivors and their families find themselves in. The focus of the intervention in such cases has been to ensure safety of the survivor and steps to move the abuser out of the premises.

Informed refusal-
a way to respect patient autonomy vs doctors legal duty to inform police

MOHFW realised the criticality of survivor- health system contact for care and provided clear directions to health systems to deal with the aspect of "mandatory reporting" in 2014. The guidelines provide a clear direction to health professionals in instances where survivors may not want to report to police but have reached the health system for treatment purposes only.

In such situations health professionals have the responsibility of informing the survivors of benefits of reporting to the police and in case they decide against reporting to police "informed refusal" would be documented and treatment would not be compromised upon. A copy of such a document stays with the patient as well as the hospital. Just as all other MLCs are reported to the police, the hospital can inform that there was a case of sexual violence without divulging any further details. So the occurrence of crime may be reported but not the survivor! The direction paves the way for ensuring right to health care as primary right of the survivor above all by upholding the primary duty of the health provider to provide therapeutic care.

6.1 Why survivors may not want to report the case to the police?

5 per cent of the cases did not want the police to be informed. There are several reasons why a survivor and/or family may not want the police to be involved. The various circumstances are presented below.

- **Abuser is from the family**

The abuser may be an uncle, father, young cousin, brother, etc. In such situations the family may not want them arrested. The perpetrator may be very young and so they don't want him to be put behind bars. They may be willing to seek counselling but not file a criminal case. The situation may be such that putting the abuser behind bars would mean taking on the economic burden of his family. While the concerns about the survivor's health and well being may bring them to the health centre or counselling centre, they do not want to report the crime to police.

> ***An 8 year old girl*** *was brought to the casualty by her mother. The girl had been sexually abused by her male cousin aged 11 years. The mother saw them putting on their underwears and brought the girl immediately to the hospital. The girl then disclosed that the cousin had done this to her several times in the past and there was bleeding from the vagina. However she had not told anyone about it. The mother wanted treatment for the girl and was unsure about making a police case. The boy who was only 11 years old, was her sister-in-law's son. The mother had also not consulted with her husband about making a police case. The doctor acknowledged the woman's dilemma and assured her that her child would be treated irrespective of whether or not she decides to make a police complaint. The doctor also explained to her the importance of immediate evidence collection and examination, as the incident had occurred only a few hours before. She informed her that the MLC was made, but it was not the same as a police complaint which could be made later after consulting her husband. In case she decides not to make a police complaint, no one can force her. But if she does, this evidence may be useful for the case. The mother thought about this and consented to the evidence collection and examination. She requested the doctor to preserve the evidence until the next day when she would come back with a decision regarding police complaint. This was documented by the doctor and the woman's signature was taken. The child was provided treatment and the mother was informed that should she develop any symptoms like burning micturation, pain in the abdomen or any other genital lesion, she should come*

back to the hospital immediately. In the follow up visit, the mother informed that they had decided against making a police complaint as the boy is a child, a relative. The mother informed that she has confronted the sister-in-law about this incident. They have spoken to the boy in the presence of the mother, and have decided that the boy would enter the house only when the parents are at home. Under no circumstances would he be left alone with the girls and the boy will be brought for counselling.

***AG, a 15 year old girl** came to the hospital in February 2013, reporting that she had been raped and had 2 months amenorrhea. The girl had been sexually assaulted by her cousin who had forced peno-vaginal intercourse with her in her own house, twice. He then threatened her that if she told anyone, he would tell everyone that she had asked him to do the act. Being afraid of this, she did not talk about the incident with anyone. After the incident she did not get her period for two months and that is when she reported the incident to her parents, who brought her to the hospital. At the hospital, the doctor ascertained that she was 9.5 weeks pregnant and offered the option of abortion. The girl wanted to go through with the abortion. The doctor also advised that she make a police complaint as what had happened to her was a crime. The girl clearly stated that she did not want to make a police complaint. The assailant is her cousin and she would rather not take the matter to the police. The father too was against making a complaint. The doctor informed her that as per the law, the hospital would have to intimate the police about the case as she had to be admitted in the hospital for abortion and she should tell the police that she does not want to make an FIR and the police respected that.*

- **Need time to decide**

Survivor may have rushed to the hospital for treatment and not decided to file a case. She may want to consult her family before deciding what is to be done. Certain health complaints such as burning micturition, missed periods, vaginal discharge may bring survivors to the hospital for treatment and the doctor may identify the cause as sexual violence. The survivors may not have revealed it to anyone out of fear or lack of knowledge.

SN a 5 year old child was brought to the hospital along with her mother and a community worker. The community worker had seen the girl being fondled by a man from the neighbourhood and had intervened. Along with other people, they had beaten the man. The girl was very scared and was taken to the mother.

The mother was very reluctant to make any police complaint, so the community worker suggested that they go to the hospital and ensure that the girl's well-being at least is taken care of. On coming to the hospital, the mother initially stated that she would like to make a police complaint. The examination and evidence collection was done by the doctor. However later she said that she is not sure about what to do. The girl's father too was not around and she would like to speak with him. The mother was assured by the crisis interventionist that they would assist her in whatever way they could. Treatment was provided to the girl and the mother was told that an MLC would have to be made by the hospital by way of intimation to police. However, the FIR could be made later if they decided to do so. The evidence would be preserved in the hospital until then. This was also taken in writing from the mother. The mother later came back and made a police complaint.

- **"Just want the abortion"**

The incident may have occurred several months back (2 to 5 months) and they did not tell anyone. Now they may only want an abortion or treatment and expect confidentiality.

NG, a 21 year old woman reported to the hospital at 7:00 pm in the month of May 2013, seeking an abortion. NG had been assaulted about 5 months before, by a person who lives in her sister's neighbourhood. NG was visiting her sister when the man assaulted her and threatened her to not tell anyone or he will kill her. Being very afraid, she did not report this to anyone. When the pregnancy began to show, she reported to her sister and brother-in-law about the incident. Both were very concerned and took her to a private doctor. The doctor, after hearing the history and doing an ultrasound determined that the pregnancy was 19 weeks and that he could not do the abortion. He referred her to the municipal hospital. When NG arrived at the hospital, the gynaecologist explained to her that the abortion would be provided. The doctor informed her that as per the new law, they were required to intimate the police about all cases and so she would have to do that. But she could inform the police that she did not want to file a FIR. The police constable on duty wrongly informed the girl that she would not get an abortion unless she makes a police complaint. On hearing this, the girl, without informing anyone in the hospital, left.

Despite all the assurances from the crisis interventionist and the doctors, the girl was clearly not convinced that she could get an abortion without first filing a police complaint.

She was 19 weeks pregnant then. It is likely that she resorted to an unsafe abortion in order to get the abortion, thus endangering her health or was forced to continue with an unwanted pregnancy.

- **Concern about stigmatisation of the girls**

There was an overriding concern expressed by parents and families about the stigmatisation of the girls because of various reasons, eg harassment by police, police visits and investigation becoming known to everyone in the neighbourhood, or the police complaint affecting her marriage prospects. There were also cases where the neighbourhood or *jamat* had been informed, support was sought from them but the families did not want to go through the courts. In a case of 16 year old girl who was repeatedly abused by her step father, the mother took a stand and threw him out of the house, informed their community about it and brought her to the hospital for treatment. But she did not want to file a case as she felt that the community would punish him and she wanted to concentrate on helping her daughter to overcome all that had happened. *"This should not spoil my daughter's life, she has to get married in some years"*

- **Choosing between Criminal Justice System and wellbeing of survivors**

In some cases the survivors's families may not want to go to police or courts but have taken care of the survivor. Often families don't want to go through the criminal justice system at all. They feel it is arduous to go through the rigmarole, and unnecessary as they may have already shamed the perpetrator and ensured safety of the survivor.

> ***A mother of a 5 year old** kept saying "just check if my daughter is ok"- she did not reveal anything else till she was assured of confidentiality. She then spoke about assault by neighbours but did not want to report to police. She was given time and she returned next day to say they did not want to involve the police.*
>
> ***A 17 year old girl SS,** came to the gyanecology OPD in the month of July 2013, seeking an abortion. She was referred by a private practitioner with a note stating that she was deserted by her husband and could not look after the child, hence wanted an abortion. However, since the girl looked very young, the doctor probed and asked if she was married and if there was more to the history. On this the girl confided in the doctor and told her that she had been raped. She belonged to another state and had come to Mumbai 2 years ago where she has been working as a full-time domestic servant with a family in the neighbourhood close to the hospital. On Sunday she was out with a friend when two unknown*

people forcibly got hold of them and raped them both. The friend left immediately for her village. SS did not tell anyone about the incident as she was the only earning member in her family and she was afraid she would lose her job. But when she missed her period she went to a private doctor. The doctor advised her to not reveal the incident of rape and to go to the government hospital and get an abortion. The girl and her friends were not at all keen on making a police complaint. They were poor, from another state and all that they wanted was the abortion. The girl said she would lose her job if someone found out what had happened and she did not want to risk it. The girl was informed that the hospital would need to intimate the police and this would be done by making a medico-legal case. However she need not go ahead and make an FIR if she did not wish to. The abortion would be provided irrespective of whether she made a complaint or not. However she left the hospital and later informed that she was going to the village to get an abortion.

- **Fear of losing job**

The consequences of reporting rape are borne by the survivor and her family. Many survivors fear that they may lose their job if they reported rape. It would invite scrutiny and interrogation by the police and employers may ask them to quit.

A young girl was working as domestic worker. She was raped by stranger but she did not report it. She missed her periods and realized she was pregnant. She did not know who the man was and if she filed a case, she was afraid her employer may dismiss her. She is the sole earning member of her family.

- **Fear of police harassment by marginalised groups**

Families may be forced to live in the city for their survival without the requisite documentation and papers. In such cases they are afraid of the police. In one case, a girl was raped near a public toilet by an unknown person but the family did not want to go to the police or the courts. The father was afraid of losing his job as security guard as they belonged to another state and were afraid that they would be harassed. Those who have migrated from other states or from across national borders for work find themselves in a tricky and vulnerable situation, as recording a complaint would reveal that they are not 'legal' inhabitants and may thus be deported.

It is important to state that in all cases where survivors did not want to inform police, they had taken steps towards safety of the survivor. The perpetrator had been confronted and

either thrown out of the house or measures had been taken to ensure restricted entry to the house.

PK, a 16 year old girl reported to the hospital for an abortion. She was 8 weeks pregnant and gave a history of sexual assault 2 months back. PK was a native of Bengal and had come to Mumbai only a few months before the incident. She and her family are beggars and street dwellers. One day she was kidnapped by an unknown person who kept her in a room and assaulted her for one month. Her parents did not file any police complaint because they do not have proof of residence and feared harassment by the police. PK narrated that she tried to call for help several times when she was confined, but there was no one who could rescue her. Finally the man who had kidnapped her left her at the railway station from where she found her way to her parents.

On hearing PK's history, the doctor informed her that she would get the abortion as it is only 8 weeks and she need not worry on that front. She also encouraged her to file a police complaint. However, since she had come from outside Bombay and did not have any proof of residence, she did not want anything to do with the police. She feared harassment.

PK was informed by the doctor that she will not be forced to make a police complaint by the hospital. They would make an MLC and proceed with the abortion. If the police does come to the hospital, PK was advised to tell them that she does not want to make a complaint.

6.2 Emerging Issues:

Survivors/victims may not want to report to the police due to financial dependency, or not wanting to go through court system, or because the perpetrator may be a family member whom they do not want arrested or may want time to think. A primary research study undertaken to understand survivors opinions about mandatory reporting by medical professionals, has reported that few participants supported such a reporting. Participants said that they needed to consider all the potential consequences of reporting before their experience of violence is reported to the police. Several reasons such as apprehensions that their history would become public and concerns that they would be deported were some of the reasons cited by participants for not wanting mandatory reporting (Sullivan et al, 2005).

6.2.1 Non-disclosure due to fear of police-double jeopardy

The fear of reporting to police is known to prevent disclosure and access to care for survivors. This has led families to give false histories. At the hospitals, there were also other cases where the families reported unrealistic histories and the doctors had to step in and call the police.

To illustrate:

In one case where the child was brought by mother to the hospital for treatment of genital injuries, the doctor suspected abuse and asked the mother about it. She denied it saying that the child had put broomsticks in her genitals. The doctors called the social worker and then reported to the police. Mother provided the same history to the police and despite follow up by social workers, an FIR was not filed. The police stated that the mother called it an accident and hence they do not see any reason for recording an FIR.

In another case, the mother kept giving history of girl falling on a temple bell and getting hurt in her genitals. The hospital again reported to the police but no FIR was lodged. A similar reason was offered by the police stating that the mother has given a clear history of accident and hence an FIR was not recorded.

This is a matter of concern and in both these cases, the doctors involved the social workers of the hospital and activated the Child Welfare Committees/Child Line to intervene. The children revealed that they had been sexually abused by their father. They had to be institutionalized since the mothers refused to accept or take any action. This is evidence of adverse impact of mandatory reporting laws which may push the issue underground and affect access to health care.

The precarious role of the police in both the cases despite mandatory reporting by the doctors was harmful for the children. It should have been their duty to activate the CWC in the best interests of the child.

6.2.2 Mandatory reporting - conflict with medical ethics

'Mandatory reporting' conflicts with the principles of informed consent, confidentiality and privacy.

Violation of Informed consent: The clause on mandatory reporting by health facilities severely compromises the principle of informed consent. Survivors reaching the facility

confide in the health professional based on the implicit contract of 'confidentiality of information'. But when a health professional tells the survivor that she has to reveal the information to the police irrespective of survivor's consent, survivors feel cheated. Informed consent loses its relevance and becomes only a formality in these cases as it clearly overrules survivors' autonomy to make a decision about reporting to the police. This raises concerns about health professional's primary responsibility as a carer and stereotypes survivors as helpless people incapable of making decisions for themselves. Health professionals having to comply with the requirement of mandatory reporting may feel that their responsibility ends with reporting to the police and no efforts need be made to either develop support strategies to heal the abuse or refer survivors for psycho-social services.

Threat to confidentiality: Provider-patient relationship is based on the assurance of confidentiality. A contract of confidentiality helps the patient to have an honest and open discussion with her provider. Health professionals are also able to carry out comprehensive and complete treatment when provided with all information. However, mandatory reporting poses a challenge to the very assurance of confidentiality. Survivors not wanting to involve the police may disclose the abuse and all injuries/health consequences, compromising their health.

Clashing Obligations: Health professionals have a duty to provide immediate treatment and report to the police. Provision of care versus mandatory reporting can pose an ethical dilemma for health professionals and they may have be hard put to decide whether to fulfill obligations to the survivor or be accountableto the state. For survivors who do not take the route of criminal justice system, such reporting will make it difficult for them to communicate honestly with the health professional.

6.2.3 Informed refusal: A way to respect patient autonomy vs doctors legal duty to inform police

The three hospitals are operationalizing informed refusal and implementing the MoHFW guidelines and doing their best to respect the survivors' wishes. However, even when the hospital may assure the survivor of support in the presence of the police, there were instances when the survivors left the hospital without treatment. It is critical to understand that when survivors do not wish to inform the police, it is the hospital/provider's responsibility to respect the confidentiality of the survivor. Facilities may have to lay this down as part of Standard Operating Procedures so that informed refusal is respected.

To conclude, we need to ask-Who benefits from mandatory reporting laws? The aim of mandatory reporting is clearly to seek punishment of the perpetrator and in general, to bring down such crime. But whether these aims are served and survivor's interests are protected is a moot point. Survivors do not report crime for many reasons ranging from fear of losing shelter, apprehensions about perpetrator retaliation, anxiety about loss of community support and even violent repercussions. Those working with survivors of sexual violence need to collate data related to "mandatory reporting" and the challenges it poses. This would provide much needed evidence for formulating policy decisions/ directions. The need of the hour is to expand services that provide comprehensive health care including crisis intervention and safety so that more survivors are able to seek care and support.

6.3 What can be done?

These survivors like others may be in need of health care, support, counselling and rehabilitation. In India, such services are linked to the registering a police complaint, and are denied to those who are disinclined to do so. A system such as Victim Protection Services (VPS) should be created where such victims and families can report the crime without having to go through the police system. The aim of the VPS is to provide a range of available services to the victim while respecting her autonomy and agency in deciding what she wants to do.

Victim Protection Services (VPS) must provide the following:

- Safety and security of the victim through safety assessment and planning
- Counselling to the victim and her family
- Referral for health care and follow up
- Ensure privacy and confidentiality
- Follow up plan through home visit
- Compensation
- Social support
- Mobilise economic support, skill building and so on.

It is important to recognise that all survivors may not wish to seek justice through the Criminal Justice System (CJS), but shall require support services such as psycho social support, health care, rehabilitation and welfare services to heal from abuse. The solution appears to be to delink the support and welfare services from the police and criminal justice system so that the former services are made accessible to all survivors of sexual violence.

7. Contentious Issues: Marital Rape

The changes in definition of rape brought through the CLA 2013, have provided a nuanced normative framework on rape and sexual violence, but the law retains the exception that exempts marital rape from the offence of rape. However, the law now criminalises non-consensual intercourse by the husband when the couple is separated, either de facto or de jure, whereas earlier, this was applicable only in case of de jure separation. The only other recourse in criminal law is under section 377 IPC, which is a cause for concern since it violates Articles 14, 15 and 21 of the Constitution.The Protection of Women from Domestic Violence Act (PWDVA) 2005 recognizes sexual abuse as a form of violence and lists various forms of sexual violence. Despite this law being in place, it is a matter of grave concern that the exception in criminal law is retained and sexual violence within marriage is not recognized as a criminal offence.

This chapter focuses on the data on sexual violence in India and existing evidence of women reporting sexual violence within marriage. The data are compelling and make a case for criminalizing marital rape and recognizing sexual violence in marriage as an offence. This requires legal as well as procedural changes as offences covered under Section 375 are not being registered as rape due mainly because of the attitudes of the police (apathy as well as normalization). The changes in the rape laws has prompted a rise in the reporting of sexual violence in general. The expanded definition of rape to include non peno-vaginal penetration and other non-penetrative assaults has enabled girls, boys and women to come forward and report the offence. This increased attention on sexual violence seems to have also enabled women in marital relationships to report sexual violence. But when they do so, the police and health system fail to follow due procedure because such violence is not recognized as an offence under the penal laws of the country. Moreover societal norms also do not recognize women's consent as being necessary for sexual relationships within the marital space, making the complaint of marital rape untenable.

7.1 Existing evidence on sexual violence within marriage

In India the NFHS III (2005-2006), showed that the lifetime prevalence of domestic violence (physical and sexual) was 35 per cent. The NFHS III data and other studies show that women who experience domestic violence are nearly four times more likely to experience

symptoms of sexually transmitted infections and HIV. A study of pregnant women attending an antenatal clinic, suggest self-reported physical, psychological and sexual violence in the last year at 14 per cent, 15 per centand 9 per cent,respectively (Varma et al 2007). A survey of 397 women in rural south India reported that 34 per centof women had been hit, forced to have sex by their husband (Krishnan 2005). In a similar survey, it was found that 41 per cent and 28 per cent respectively of currently married and never married women reported sexual violence in the last 12 months.33 per cent of the currently married and 40 per cent of never married women reported seeking any help for sexual violence. In the same survey, married women's responses to a hypothetical question about what would happen if they refused sex was revealing. 36.7 per cent of married women reported that they would be forced to have sex.

A cross sectional study conducted by Santhya et al in 2007 on unwanted sex among young married women acknowledged that methodologically there is likelihood of underestimate of sexual violence within the marriage by research studies. This is because the study findings revealed that women may experience unwanted sex without physical violence and in these instances; these women are less likely to label these sexual contacts as coercion by husband. A study by International Centre for Research on Women (ICRW) in 2014 draws attention to a high prevalence of intimate partner violence in India as reported by men and women. At the aggregate level, more than half of the women (52 per cent) surveyed reported experiencing some form of violence during their lifetime, and three in every five men (60 per cent) reported ever perpetrating any form of intimate partner violence against their wife/partner. The higher number of men reporting IPV is clear evidence of the social sanction to this violent behaviour. That so many men reported perpetrating physical, emotional and sexual violence against partners is something that requires attention as they know they can have complete immunity, despite existing laws that criminalise such behaviour.

Sexual violence in marriages results in adverse outcomes such as women's inability to negotiate condom use or contraception, and their higher vulnerability to HIV/AIDS and other sexually transmitted infections (Silverman, 2010; Chan and Martin, 2009; Stephenson et al, 2006). Sexual violence is also linked with poor access to prenatal care, still births, Pelvic Inflammatory Diseases (PIDs) and attempted suicides (Chowdhary and Patel, 2008; Stephenson et al, 2006, Khanna et al, 1998).

Physical and sexual intimate partner violence is associated with miscarriage and reproductive health services should be used to screen for spousal violence and link to

assistance (Johri et al, 2011). A longitudinal study in Goa spanning over a period of three years found that women facing spousal sexual violence are at increased risk of contracting sexually transmitted infections which were diagnosed clinically, during the study. This study recommended the screening of women complaining of STIs for intimate partner violence by healthcare professionals for providing comprehensive treatment to these women (Weiss et al, 2008).

7.2 Domestic Violence (DV) survivors reporting sexual violence at hospital-based crisis centre

The above are cases where women have reached the health facility or police with a complaint of marital rape. It is well evidenced that women face sexual violence within marriage. The experience of several counseling centers so far has been that women narrate experiences of sexual violence from husband as part of their history of violence and they may not directly seek services after an episode of sexual violence due to stigma attached. Women begin with talking about physical, emotional and economic abuse and only after trust is established that they speak out about sexual violence by partner.

At Dilaasa hospital-based crisis intervention department, from a total of 2545 women registered during 2001-2012, 78 per cent (1991) of these women were currently married, 14 per cent were separated/widowed or deserted and 8 per cent were never married.

Of those who registered at the centre, 46 per cent reported sexual violence within marriage, where as 13 per cent women also reported that their spouses withheld sex, which has to be understood as a form of sexual violence too. Amongst them, 51 per cent currently married reported SV, 34 per cent of the women who were separated/divorced/reported SV and 21 per cent of the never married women.

Of the women who were currently married, 51 per cent (1013 of 1991)women reported experiencing sexual violence. 81 per cent of the women were between 18 to 35 years, 17 per cent were 36 to 50 years. So these are women who are very young and are living in abusive relationships and are being subjected to sexual violence. Studies on sexual violence show that the first sexual contact itself is forced and unpleasant. 91 per cent women reported that onset of violencesince the beginning of marriage. Women experiencing sexual violence are less likely to use contraception due to sexual control by the partner. 48 per cent women had more than 3 children, 25 per cent had 2 children. 5 per cent were currently pregnant. 19 per cent women had no children as these were women married for less than 2 years.

The various forms of sexual violence reported by women are listed in Table 7.1. The forms of sexual violence as per offence of rape under Section 375 are forced sexual intercourse, forced acts against will and insertion of objects in woman's genitals. 68 per cent of the women have reported forced sexual intercourse which means that they were forced by their husband against their will, this refers to forced penile penetration. Another 8 per cent women reported that they suffered forced anal or oral penetration and 1 per cent reported that objects were inserted in their genitals. All these incidents clearly make a case under the criminal act of rape under Section 375.

It is well-acknowledged that most married women may not have much sexual agency and therefore rape within marriage may be more common than is reported here. That is the reason why this data are important. When 51 per cent of DV survivors have reported some form of sexual violence it must be of severe nature and unbearable for them, so this should not be dismissed as a phenomenon that has to do with the gendered nature of sexual relationships. For all these women, there is no legal recourse at the moment if they want to file a criminal complaint due to the exception in Section 375 IPC.

The case records analysis shows that women suffer forms of sexual violence, other than marital rape. 21 per cent women reported that the husband was not using any contraceptive nor was allowing her to use one, thus exerting complete reproductive control over her. 5 per cent were sexual abuses by family members other than the husband, 1 per cent of the women reported that husband forced them to have sex with others, and 1 per cent of the women reported that the husband sexually abused their daughter.

Table 7.1 : Forms of Sexual Violence

Forms of marital rape*	**Number**	**Percent**
Forced sexual intercourse	679	68
Made to do sexual acts against will (oral/anal/porno)	70	8
Inserting objects	10	1
Other forms of sexual violence		
Withholding sexual pleasure	285	28
Sexual advances from other family members	51	5
Denying/refusing use of contraceptive/forcing her to have children	208	21
Forcibly using her to entertain others	7	1
Sexual abuse of daughter	7	1

Source: Dilaasa service records , *Multiple responses

Of the women who reported sexual violence, 58 per cent came to the crisis centre through the health system as they had other health complaints. The health complaints that brought them to the hospital varied: while 33 per cent reported assault, 10 per cent reported an attempted suicide, 14 per cent had some reproductive health complaint while 1 per cent reported attempted homicide. These are the immediate health consequence of abuse that required treatment.

Women were also asked about how the ongoing abuse has affected their physical and mental health. Most women who reported sexual violence also reported other forms of violence such as physical, emotional and financial.

Table 7.2 : Other forms of violence reported

Form of violence*	Number	Percent
Physical violence	930	92
Emotional Violence	1007	99.4
Financial Violence	892	88

Source: Dilaasa service records ,*Multiple responses

80 per cent women reported physical health consequences such as injuries (47 per cent), abortion/miscarriage (21 per cent), 5 per cent women reported RTIs and 1 per cent reported prolapse of the uterus too. A large number of women, 91 per cent reported that they were suffering mental health consequences. Of these, 26 per cent had attempted suicide, 17 per cent reported thoughts of ending life, 61 per cent women reported feeling nervous and tensed and 31 per cent reported that they were frightened and lived in fear all the time.

In terms of help seeking, 50 per cent of the women had gone to the police and filed a complaint of domestic violence and in all cases it was a Non Cognisable offence (NC) that was registered by the police.

7.3 Women reporting marital rape

Between 2011 and 2015, at least 13 women reported marital rape and sought medico-legal support. The forms of sexual abuse are forced peno-vaginal, forced peno-anal, forced oral sex, use of foreign objects such as rods, and so on. Many of these were accompanied with physical assault too. Women came to the health facility as they had sustained injuries and wanted medical attention and treatment. While some reported directly

to the hospital, others were brought in by the police. Of the 13 women, five were currently living with their partner and eight were separated from the husband due to severe violence.

Eight of them reported to the hospital directly and in all these cases the rape incident had occurred between 1 to 5 days. The health consequences had brought them to the hospital as they reported injuries on the genitals/thigh/breasts due to the brutality of the violence. Of those brought by police, only in one case had the incident taken place 2-3 days back. In all other cases, the incident had taken place 2-6 months back. While the woman had immediately reported the incident to the police, their medico legal examination had been delayed as the police were not sure of what to do. Such delays lead to loss of evidence and the woman's health complaints remain unaddressed. One of the women was currently pregnant. In all the eight cases where women were currently separated from the husband, the police should have filed case of rape as per Section 376B but this had not been done. In two cases the police had registered cases under IPC 498A and/or IPC 377.

Age	Years of marriage	Brought by	Time since incident	Legal status	Brief history
			SEPARATED		
22 years	2 years	Self and sister	2 to 3 days	No FIR only complaint registered	Living separately due to physical abuse, sexual abuse and demands of money. Husband caught her while she was returning from work, demanded money, forced sex on her and doused her with kerosene. She was scalded and reported to the hospital.
27 years	Separated for 2 years	Brought by self	4 days after the assault	498 A previously, Police did not know what to do	Survivor reached the hospital for treatment as she had faced forced oral and anal sexual violence. Bruises on thighs, breasts, neck , bite marks on mouth
28 years old	6 years	Police	2 months	PWDVA filed No FIR by police	Survivor left marital home 2 months back due to physical abuse and forced sex. Continued threats of forced sex so went to police

Age	Years of marriage	Brought by	Time since incident	Legal status	Brief history
29 years	3 years, husband filed for divorce	Brought by self	Reached 1.5 days after sexual activity	Husband has filed for divorce. Police did not know what to do	Woman stated that husband had sex with her,she wanted to know whether evidence for sexual activity can be collected so that she can produce the same in court to prove that husband continues to visit her and have sex with her. The woman did not want the divorce.
32 years	Married for 1 year	Brought by police	2 to 6 months back	498 A and 377	Survivor currently pregnant.
33 years old	Married for 5 to 7 years	Self and mother	Reported after 2 years of assault	No FIR	Recurring threat of sexual abuse by husband.
36 years old	Married for 14 years	By police	4 days after assault by husband, threat of sexual abuse of son	No FIR	Husband forced her to perform oral, anal and vaginal sex. Threatened to sexually abuse son, Sustained injuries over forearm, injuries over anus.
38 years old	Married for 20 years	Police	3 years back, Sexual abuse of son	Divorce and PWDVA, No FIR by police	Separated for 7 years. When the husband attempted to sexually abuse her son, she came to the police and also complained about marital rape 3 years back.
MARRIED					
19 years	Married for 3 months	Brought by her mother	3 days after assault	Case filed under 377, 498 A and 506	Survivor told her mother about the sexual violence by husband.
20 years	Married for 6 months	Brought by sister	Reached one day after the assault	wanted to file a police case	Husband used to have sex violently with the survivor, sustained several injuries.

Age	Years of marriage	Brought by	Time since incident	Legal status	Brief history
24 years	Married for 6 months	Brought by parents	2 days after assault	Police did not know what to do	Forced oral, anal and vaginal sexual assault, sustained injuries.
26 years	Married for 2 years	Brought by police	Reported 3 months after episode	Complaint taken but copy not given.	The husband has been absconding for past 3 months .
31 years	Married	Brought by self	Reached 1 day after the assault	Police did not know what to do	Came to seek treatment, bruises on thighs, anal abrasions , bruises over arms. Wanted to file police case

7.4 Redressing sexual violence within marriage

The narratives/experiences of women reporting sexual violence from their husbands as presented above cannot be ignored. Marital rape almost seems like a daily phenomenon among a large number of women who may also be experiencing other forms of domestic violence.

Even women who have separated from their husband because of domestic violence are reporting rape by their husbands. That women are speaking out and reporting sexual abuse from their partners/husbands indicates that they want it to stop and also be able to report it. All women may not seek legal recourse but are definitely seeking health care for complaints arising from the abuse. But even in the 13 cases where women reported marital rape to either the police or the hospital, and wanted to file a FIR and have their husbands arrested, the response of the police was problematic. In all cases where women were separated from their husbands, a case of rape should have been registered by the police. But the attitude of the police and the lack of any standard protocols in place were responsible for non-registration of offence under Section 376 B IPC. The police seem to accept such abuse as a part and parcel of marriage.

One of the women also narrated her experience with two other public hospitals in the city that refused to conduct a medico-legal examination as she reported that she was raped by her husband. She lost two days before she was referred to the hospital where a crisis centre is located.

This narrative indicates that the response of hospitals too may be severely compromised as they too may not recognize marital rape as 'rape" that requires a medico-legal examination.

The law is not on the side of women who have been abused and are currently married. With the clear exception granted to the husband under Section 375 IPC, she is left with absolutely no option if she wants to file a criminal case. As seen in the earlier section, the incidents reported by them were severe and had caused them injuries too. They were so scared that they had rushed to get treatment and wanted to take action against their husbands. The existing provisions of 498A are not clearly defined so they could not register marital rape under that law. This section is already quite problematic as there is a lot of prejudice against women who file 498 A. The only silver lining being the PWDVA where women can file cases of marital rape but they would have to wait for another episode before a criminal case can be filed!

8. Compliance to the guidelines and protocols

The compliance to protocols and guidelines:

The review of the MLCs records showsthat doctors and health facilities can be trained to follow these in all circumstances. It was found that doctors were able to operationalize informed consent for all steps such as consent for examination, treatment, evidence collection and informing the police. Informed refusal was documented and respected when survivors did not want evidence collection or when they did not want police to be informed. In all such cases the nodal medical officers interfaced with the police and ensured that the survivors were not harassed.

History of sexual violence has been recorded in detail which is crucial for the medico-legal procedure. Doctors have asked about the nature of sexual violence whether penetrative/non penetrative in all cases, use of condom, threats and abuse as well as activities post assault.

Treatment has been provided in all cases as per the symptoms presented and the history provided. In many cases survivors have been asked to follow up in case of any pain or swelling that may come up later.

1. Informed Consent:

A critical aspect of operationalizing informed consent for examination, treatment, evidence collection and informing the police, is to provide complete information about the procedure, the benefits of it and the consequences of not doing any of these. 83 per cent of the survivors consented to the procedures, but 17 per cent refused at least one of these. In all such cases, informed refusal was documented by the doctors. Informed refusal means that the person has been informed about the benefits and consequences of a certain procedure and has clearly told the doctor that she does not want to proceed with one or all of it.

Of those who did not wish to proceed with the medico-legal procedures, the hospitals respected the same in all but six cases. These included survivors who only wanted treatment. The hospital team including the administrator, examining doctor and social worker had to interface with the police to protect the survivors' confidentiality. In cases that involved children, the police spoke to the guardian before acceding to their refusal to file FIR. The

six cases where it was not possible to respect survivors' refusal were mostly those of children less than 18 years. In one case an adolescent girl, underwent an abortion but did not want the DNA test to be conducted as she did not want any forensic evidence against her lover, the hospital was not able to respect her wish as a FIR had already been filed, the boy had been arrested and the case was under investigation.

2. History

This forms an important part of the medico-legal examination, merely stating 'alleged history of rape' is not useful. Documenting history is important both for forensic and clinical purposes. In doing so, the doctor must ensure that relevant history related to the incident of sexual violence is taken, nature of sexual violence whether it was penetrative or not, amongst others. It was found that in 96 per cent of the cases there was no mention of irrelevant details such as past sexual history.

The nature of penetration was recorded in 97 per cent of the cases. In the case of small children or survivors who were drugged, such information could not be recorded as survivors could not give these details. In 92 per cent of the cases, details about whether a condom was used or not, whether ejaculation occurred or not had been recorded.

Another important aspect of history, is documenting the activities undertaken by survivor after the incident such as urinating, douching,etc that may lead to loss of evidence. Such information was recorded in 97 per cent of the reports. Similarly history of drugging, intoxication and of physical assault/use of threats were recorded in 97 per cent of the reports.

3. Evidence collection

It is essential that relevant evidence be collected based on the history of sexual violence. This is an important aspect of a gender sensitive and scientific practice. In 94 per cent reports, relevant body samples were taken and relevant genital samples collected in 92 per cent of cases. This indicates that the doctors collected evidence based on history and did not mechanically collect swabs from the survivor's body.

4. Gender sensitivity

One of the main concerns with medico-legal examination in rape is the comments on past sexual history/conduct of the survivor. As reported earlier, in hardly any report was there explicit mention of irrelevant details about past sexual history. Such inference is

often drawn based on comments such as torn or intact hymen or size of the vaginal introitus which doctors routinely record as part of their examination and these are then used to cast aspersions on the character of the survivor especially when she is an adolescent or an adult woman. It was found that in 85 per cent of the reports only relevant findings on the hymen were mentioned such as fresh tear, bleeding or swelling. However in 15 per cent of the cases, irrelevant comments had been made by doctors despite training. This indicates how deeply entrenched is this notion amongst doctors.

Table 8.1: Compliance to the protocol and guidelines

Compliance to the protocol and guidelines	Number	Percent
Whether informed consent/ refusal operationalized?	722	99
Whether consent has been sought from an appropriate person?	716	97
No damaging or irrelevant details in history	645	96
Nature of penetration is recorded correctly wheneverapplicable	645	97
Details of condom use, ejaculation have been recorded	645	92
Details of activities leading to loss of evidence have been recorded	645	97
History of drugging ,intoxication is recorded	645	97
History of physical assault, threats, weapons used is documented	645	97
Relevant body samples collected	645	94
Relevant genital samples collected	645	92
Relevant comment on Hymen	647	85

Multiple responses

5. Opinion

It is the doctor's duty to formulate a medical opinion based on the medico-legal examination. The routine practice in India is for the doctors to merely state "Opinion pending FSL results". But there is legal and clinical obligation on the doctor to correlate the history and clinical examination to formulate an opinion. The doctors in these hospitals have been trained to provide such a provisional as well as a final opinion. The review of medico-legal forms showed that an opinion was formulated in 92 per cent of the cases where it was relevant. There were several cases where this was kept blank thus reiterating the need for continued training and supervision. The cases of elopement where there was no history of sexual violence and the cases where the survivors had not consented to a medico-

legal examination as they only wanted treatment or counselling were categorised as ones that were not relevant for formulating opinion.

Table 8.2 : Formulation of Opinion

Opinion Formulated	Number	Percent
Yes	513	92
No	47	8
Total	560*	100

*Cases where survivors did not want a medico-legal examination (77) and Cases of elopement (91)

The opinions were further reviewed to see whether these mentioned critical elements such as findings related to use of force, time since assault and age of survivor.

Table 8.3 : Elements of Medical Opinion

Critical elements	Number	Percent
Use of force	421	75
Time since assault	451	81
Age of survivor	221	40

Multiple responses

It is commendable that important factors such as use of force and time since assault have been included in formulating opinion and one can say that these are drafted based on facts of the case and not in a mechanical manner.

Ongoing training, monitoring and supervision

The three hospitals have been conducting training of doctors every six months, providing on-call support and handholding by CEHAT team, reviewing MLC documents on a monthly basis to identify gaps and bringing it to the notice of the doctors. Consistent support of health care providers through the 24*7 teleline, repeat trainings and monitoring mechanisms in coordination with CEHAT team has led to a systematic and sensitive approach to sexual violence survivors.

Respecting sexual rights of adolescents

As reported in chapter five-Elopment/Runaway Marriages, the hospitals were able to respect the autonomy and agency of adolescents. This was possible as the hospitals created the necessary SoPs and facilitated the interface with hostile parents and police. When girls did not want to stay with their parents, hospitals geared up to coordinate with agencies such as CWCs and even hostels. This is important as girls face various forms of abuse in their parental homes.

Recognition of marital violence as form of sexual violence

As stated in chapter 7-Contentious issues: Marital Rape, all the women who reported rape by their husbands were regarded as 'cases of sexual violence' in the three hospitals. The proforma was filled, treatment was provided, police were informed and they were referred to social workers. This is important as doctors need not get bogged down with the legal definitions of rape as that is for the courts to decide. The health response must recognize marital rape as sexual violence and respond to it with the same sensitivity and rigour as all other cases.

9. Analysis of court outcomes

This chapter explores whether a systematic medico legal response plays any role in the court trials of sexual violence. This has been done through analyses of court judgements. The findings suggest that police, prosecution, and judiciary continue to subscribe to unscientific aspects of medico legal examinations. An analysis of 14 judgments in the light of medico legal evidence and factors that led to conviction and acquittals are presented.

Analysing legal outcomes

All survivors received medical care and psychosocial support. Having ensured a comprehensive health care, what of legal justice to the survivors? For this, court judgments for 14 survivors were procured. The contents of the judgements were segregated in an Excel sheet on the basis of age, nature of sexual violence, health consequences sustained, and results of forensic science results. These judgements were delivered between 2010 - 2012[7].

Of the 14 case judgments, only in six were convictions secured, while the rest were acquittals. Factors such as age of the survivor, type of sexual violence, nature of health consequences, forensic findings and health professional's deposition were considered for analysing the outcomes of 14 judgements. Table 9.2 presents specific components from the 14 judgements that played a role in convictions and acquitals.

[7] The survivors of the period 2010-12 could not benefit from the expanded definition of rape as per Protection of Children fromSexual Offences' (2012) and 'Criminal Law Amendment to Rape'(2013). The previous laws on rape did not consider penetration of mouth and vagina, penetration by parts other than penis and non-penetrative forms of violence as rape.

Table 9.1: Profile of 14 survivors for which court judgements are available

Age		0-12	13-17	18 and above
No. of survivors		5	2	7
Relationship with Perpetrator	Known	4	2	5
	Unknown	1	0	2
	Total	5	2	7
Type of sexual violence	Penetration	4	1	7
	Non- penetration	1	1	0
	Total	5	2	7
Presence of physical injuries		0	0	3
Presence of genital injuries		5	0	2
Presence of intoxicant	Yes	0	1	2
	No	5	1	5
	Total	5	2	7

Table 9.2 Nature of medical evidence

Age		0-12	13-17	18 and above
Semen/ blood	Yes	1	0	4
	No	4	2	3
	Total	5	2	7
Health consequences	Physical	3	0	3
	Psychological	0	1	3
	Total	3/5	1/2	6/7
Judgement	Conviction	2	2	2
	Acquital	3	0	5
	Total	5	2	7

Factors leading to convictions

Ensuring availability of medico legal documentation and health professionals to the courts: Availability of medico legal records and detailed documentation by health professionals seems to have played an important role in the trial process. The court took cognisance that documentation was nuanced and included forms of non-penile penetration as well as attempt to penetration.

Reasonable explanation for lack of injuries: In the six cases, where convictions were secured, not all survivors sustained injuries. Health professionals were able to substantiate

reasons for lack of injuries. Aspects such as delay of more than a month in reporting to the hospital, being offered a drink comprising of a stupefying substance and hence inability to resist the attack were cited as reasons for lack of injuries. Health professionals had documented the health consequences in the form of pain in urination, lower abdominal pain, and attempt to end one's life as post sexual violence consquences. These detailed note spersuade the courts to consider such health consequences as medico legal evidence.

In one particular instance, health professional had noted inflammation in the genital region in a child survivor of five years. The court questioned the medico legal evidence asking the health professional to explain if inflammation could be an outcome of a sexually transmitted infection. The health professional explained that her examination findings noted that inflammation was a result of injury. She also drew attention to the fact that presence of a STI in a five year old is a sign of sexual violence.

Effective explanantion for negative forensic reports: Of the six survivors where conviction was secured, forensic evidence was collected from five. The sixth survivor had reported to the hospital after a month, hence no evidence could be located from the body of the survivor. For the five survivors reporting before that period of 72 hours, forensic evidence had been collected in the form of blood samples, urine samples, nail cuttings, swabs for detection of semen/sperm, etc.

Medico legal evidence analysed by forensic science laboratory (FSL) tested positive in case of two survivors as semen stains found on body of the survivor matched the perpetrator. In instances where the forensic reports were negative, health professionals were able to explain it in the court.

In one instance, despite the survivor reaching the hospital immediately after the episode of sexual violence, swabs collected for seminal stains did not test positive. The health professional explained that because survivor was menstruating at the time of sexual violence and at the time of examination, it is possible that evidence was lost with menstrual blood. Such an explanation was admitted by the court.

In another instance, doctor was also able to explain that often survivors are not able to recall whether there was emission of semen, if semen is not emitted or ejaculation has occurred oustide the body swabs would not test positive. Such explanations were given credence by the courts.

Well-equipped prosecution: For all six survivors, the prosecution was well prepared and had reviewed the medico legal documentation along with the health professionals. They had also ensured that doctors were called as expert witnesses. Doctors could only come to the courts in four cases to depose evidence. In two instances where the doctors could not be present, medico-legal documentation was presented appropriately by the Public Prosecuter (PP). PPs in all the six convictions were aware that even negative medical evidence needs to be presented to the court to ensure that non-disclosure of status of medico-legal evidence is not looked by the court in a negative manner.

Factors leading to acquittal

Deficiencies in presentation of injuries as evidence: In the cases where acquitals had resulted, medico legal evidence was in the form of injuries. Three survivors sustained physical injuries and four sustained genital injuries. Despite deposition by the doctor in the court, the prosecution was unable to link these injuries to the episode of sexual violence. Prosecution could not offer an explanation when the defense counsel raised questions such as whether injuries may have emerged from consensual sexual activity. In cases, where there was absence of injuries on the survivors, PPs assumed that health professionals need not be called to depose in the court. When questions were raised by the court on absence of injuries the Prosecution could not adequately respond as they were unaware of the limitation of medical evidence. Had they summoned the doctors, the situation could have been different with the possibility of doctors bringing clarity on this issue to the Court.

Inconclusive presentation of trace evidence: Amongst the eight survivors, trace evidence was found in four survivors in the form of semen traces and presence of alcohol in blood. Due to the fact that three of the four survivors were adults and in a relationship, the court raised the possibility of the semen evidence being of the partner from the consensual relationship and asked the prosecution to explain it. Prosecution could have disputed such an argument based on the case narration of the survivor. Survivors had clearly stated that the perpetrator was a known person but they were not in a relationship with them. Further directions could have been sought from the court to assess whether the semen evidence of the consensual partner matched that of the perpetrator. The prosecution however, could not bring these aspects to the notice of the court. DNA examination and matching could have been sought to assess whether the semen traces belonged to the consensual partner but even such a direction was not sought, leaving the survivors at a disadvantage.

Even instances where no trace evidence was found on survivors, medico-legal records provided clarifications for it. Medical opinion of the health professional was recorded for lack of trace evidence. Such an opinion stated the perpetrator had not emitted semen on the survivor's body, survivor reported to the hospital after delay of a week and survivor being assaulted by finger penetration, hence semen could not be found. Despite such clear medical interpretation, prosecution was not able to present these findings in the Court.

Inconsistences in survivor deposition and medico legal documentation: An important responsibility of the Public Prosecutor (PP) is the preparation of the survivor before making court appearances. Each potential evidence to be presented by the PP has to be examined and verified. If this is not done and contradictions appear, then it can mar the chances of successful prosecution. In one instance, contradiction appeared in the medical evidence presented by the health professional in the court and questions raised by the survivor against medico-legal documentation. Survivor stated that she had sustained genital lesions after the violent epiode which the HP had not recorded. The HP maintained that at the time of examination no lesion was found on the genitals. The PP was not able to salvage the situation, and resulted in an issue indicating inconsistency in the statements of the survivor and the Health professional. The court upheld that a health professional is a disinterested party and hence there is no reason to record false reports. The court stated that had the survivor sustained genital lesions post the assault, she could have visited another HP and that medical record could have been brought to the court. Such a record was not sought by the prosecution. Unfortunately such inconsistences were used by the defense counsel to discredit survivor's narrative. Hence proactive prosecution is needed to bring medical evidence to clarify any suspicion observed by the Court in relation to acceptance of any evidence and testimony.

Overambitious prosecution: Eagerness on the part of prosecution also affected the chances of conviction.

In one instance police prepared a charge sheet of gang rape despite the survivor stating that there was only one perpetrator. The focus of the prosecution became proving the offence of gang rape, but required evidence was found to be lacking.

In another instance, the survivor reported assault from the perpetrator by insertion of fingers in the vagina but the police had included charge under rape. The law on rape till 2012 required an attempt to penetration by penis and did not prosecute use of objects, fingers, etc. If appropriate sections of Indian Penal Code were charged for the offence on

insertion of fingers in the vagina, the chances of getting a conviction would have certainly increased.

Even if the charges (which provided higher punishments) were levelled with the intention to punish the perpetrator with a severe sentence, it backfired when the prosecution failed to prove its point; with the accused going scot-free and the victim denied justice for no fault of hers.

Fear of social incrimination: Amongst the eight survivors where acquitals were declared, three survivors withdrew from court appearances during trial as they did not want to pursue the legal battle any longer. Survivors and their families cited reasons such as wanting to move on, not wanting the survivor to be labelled, fear of future prospects of survivors marriage amongst others. Amongst the survivors who withdrew the period of trial ranged from 1.5 years to 3 years.

Emerging issues

Gaps in understanding medico-legal evidence by courts

Medico-legal evidence was largely understood in the form of injuries. The presence of genital and physical injuries were found to be an important factor in the process of conviction as was seen in the findings. But inconsistencies were found in accepting injuries as evidence in cases of adolescent survivors. Courts raised questions on whether the injuries were related to consensual sexual activities. Further biases were reflected in court proceedings when health professionals were asked for results of the two finger test - such a test was used in the past by health professionals to determine the past sexual conduct of a survivor, when this has been banned.

The courts displayed a lack of understanding of health consequences of sexual violence such as burning micturition, pain in abdomen and possibility of sexually transmitted infection in children. Despite medical records indicating the nature of treatment offered to these survivors in the form of analgesics for pain relief, antibiotics for treatment of sexually transmitted infections and provision of emergency contraception to avoid an unwanted pregnancy - the prosceution was not able to link the health consequences as outcome of sexual violence.

Another issue of concern is the inconsistent interpretations of biological evidence (presence of semen stains, alcohol in blood). Whether positive biological evidence plays any role in the conviction or acquittal could not be determined in these judgements.

The court judgements also reflected stereotypical beliefs and biases that existed against survivors of sexual violence. If the survivor knew the perpetrator, court drew the inference that the possibility of the act being a consensual one cannot be ruled out. Such an inferences proved to be damaging to the survivor and also to the outcome of the court trial. When the perpetrator was a known person or a partner, such cases were seen to be less deserving of justice.

This analysis underscores the need for training of health professionals to carry out systematic and scientific medico legal examination and care. This needs to be supported with training of the police, prosecution and judiciary to explain the scope and limitations of medical evidence. Interface amongst these stakeholders is pertinent in order to enable survivors in their pursuit for justice.

10. Way forward

The hospitals receive survivors of sexual violence every day and the three hospitals have been able to establish gender sensitive protocol to respond to all cases. This has been made possible by continued training, supervision and review.

As presented in the report, hospitals receive a range of cases of sexual violence and it is important that the doctors approach each case sensitively and with an open mind. Such as approach enables the survivors to narrate what has happened, which is critical for treatment as well as her access to justice. In doing so, the hospitals have been able to harness all available technical support such as lawyers, social workers, translators, special educators, amongst others and have been able to interface with the police, CWC and courts effectively. The hospitals have thus been able to address the specific needs of all survivors of sexual violence including boys, transgender persons as well as persons with disability.

As a regular practice trained doctors seek to establish a rapport with the survivor directly and enable her to speak out without getting carried away or limiting themselves to the history given to police. This is an important aspect that must become the routine practice in all health facilities. Often the police and parents bring girls who may have run away from home or have "gone missing" and expect doctors to 'rule out rape' or in case of women the police and family want to know if she was raped. The expectation here is for doctors to check if there are injuries and/or if the hymen is intact. Neither of these are present in many cases of rape. The focus therefore of medico-legal examination needs to be on the health and wellbeing of the person and not a mechanical exercise of collecting swabs or commenting on genitals. Hospitals have done just that since 2008 and it is to their credit that the model set up here has been acknowledged by the Government of Maharashtra as well as the Government of India.

As highlighted in the report, there are several contentious issues such as the mandatory reporting by doctors, the increase in age of consent to 18 years which criminalises consensual sex for adolescents (16 to 18 years), non recognition of marital rape under the rape law which need to be addressed at the earliest. These hospitals, in partnership with CEHAT, have paved the way by approaching each case sensitively and addressing it comprehensively taking into consideration law, ethics and gender.

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ANNEXURE 1

79 to 85
Medical Legal Examination Document

Annexure 2

1. Gender

Gender	Frequency	Percent
Male	15	3
Female	511	97
Transgender	2	0
Total	**528**	**100**

2. Marital Status

Marital Status	Frequency	Percent
Married	70	13
Single	440	83
Divorced	5	1
Separated	4	1
Widowed	9	2
Total	**528**	**100**

3. Year of Registration

Year	Frequency	Percent
2008	8	2
2009	15	3
2010	30	6
2011	34	6
2012	34	6
2013	90	17
2014	234	44
2015	83	16
Total	**528**	**100**

4. Pathway to Hospital

Pathway to Hospital	Frequency	Percent
Survivor-hospital	104	20
Survivor-police	424	80
Total	**528**	**100**

5. Age and Pathway to Hospital

Age and Pathway to Hospital	Survivor-Hospital	Survivor to Police to Hospital	Total
0-12 years	39	193	232
	17%	83%	100%
13- 17 years	23	111	134
	17%	83%	100%
18 years & above	42	120	162
	26%	74%	100%
Total	**104**	**424**	**528**
	20%	**80%**	**100%**

6. Time lapse

Time lapse since incident	Frequency	Percent
less than 1 day	263	50
2-3 days	66	12
4-7 days	46	9
8 days to a month	46	9
More than a month	86	16
NA	21	4
Total	**528**	**100**

NA: Refereed for counselling, Proforma not available/not filled

7. Age and Time Lapse

Age and Time Lapse	Less than 1 day	2-3 days	4-7 days	8 days to a month	More than a month	NA	Total
0-12 years	145	34	19	13	10	11	232
	62%	15%	8%	6%	4%	5%	100%
13- 17 years	51	16	14	13	36	4	134
	38%	12%	10%	10%	27%	3%	100%
18 years & above	67	16	13	20	40	6	162
	41%	10%	8%	12%	25%	4%	100%
Total	**263**	**66**	**46**	**46**	**86**	**21**	**528**
	50%	**12%**	**9%**	**9%**	**16%**	**4%**	**100%**

NA: Referred for counselling, proforma not available / Not filled

8. Age and Relationship

Age and Relationship with Abuser	**Unknown**	**Family**	**Acquaintance**	**Intimate partner**	**Dont Know**	**Total**
0-12 years	45	32	146	0	9	232
	19%	14%	63%	0%	4%	100%
13- 17 years	38	22	66	6	2	134
	28%	16%	49%	5%	2%	100%
18 years & above	27	15	89	26	5	162
	17%	9%	55%	16%	3%	100%
Total	**110**	**69**	**301**	**32**	**16**	**528**
	21%	**13%**	**57%**	**6%**	**3%**	**100%**

9. Nature of Past abuse

Nature of Past Abuse	**Frequency**	**Percent**
Physical abuse	3	1
Sexual abuse	83	16
Physical & sexual abuse	38	7
No abuse	388	73
Verbal abuse	2	0
Stalking	3	1
Don't know	11	2
Total	**528**	**100**

10. Luring

Luring	Frequency	Percent
Lured with cash/food/toys	49	9
Misled	40	7
Job	10	2
Not lured	351	67
No information	67	13
Kidnapped	4	1
Blackmailed	7	1
Total	**528**	**100**

No Information: No history as survivor too small or unconscious

11. Disclosure of Abuse

Disclosure of Abuse	Frequency	Percent
Caught the accused in the act	81	15
Informed immediately after assault.	183	35
Health compliant led to disclosure	72	14
Future abuse/ threats led to disclosure	105	20
Police found her/ rescued her & brought to hospital	35	7
Caregiver asked her then she revealed	29	5
Pregnancy	23	4
Total	**528**	**100**

12. History of drugging

History of drugging	Frequency	Percent
Yes	58	11
No	454	86
Don't know	16	3
Total	**528**	**100**

13. Threats

Nature of threats	Frequency	Percent
Verbal threats	160	30
Threatened with weapons	21	4
Both	27	5
None	295	56
Dont know	25	5
Total	**528**	**100**

14. Age of perpetrator

Age of perpetrator	Frequency	Percent
Adolescent	41	8
Adult	465	88
Dont know	22	4
Total	**528**	**100**

15. Activities leading to loss of evidence

Nature of Activities	Frequency	Percent
Voided Urine	406	79
Changed Clothes	330	63
Eaten Food	346	66
Ingested Food	356	68
Bathed	288	56
Douched	206	40
Defeacated	306	58

Multiple Response

16. Use of Condom

Use of Condom	Frequency	Percent
Yes	29	5
No	86	16
NA	252	48
No information	161	30
Total	**528**	**100**

NA- Non penetrative assault

17. Age and Penetrative Assault

Age and Penetrative Assault	Yes	No	Don't know	
0-12 years	63	147	22	232
	27%	63%	10%	100%
13- 17 years	51	62	21	134
	38%	46%	16%	100%
18 years & above	90	43	29	162
	56%	26%	18%	100%
Total	**204**	**252**	**72**	**528**
	39%	**48%**	**13%**	**100%**

18. Age and Injury

Age and Injury	No	Yes	
0-12 years	138	94	232
	60%	41%	100%
13- 17 years	92	42	134
	69%	31%	100%
18 years & above	85	77	162
	53%	47%	100%
Total	**315**	**213**	**528**
	60%	**40%**	**100%**

Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Violence and Health

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